

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Parts 17, 51 and 52

RIN 2900-AO88

Per Diem Paid to States for Care of Eligible Veterans in State Homes

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to reorganize, update (based on revisions to statutory authority), and clarify its regulations that govern paying per diem to State homes providing nursing home and adult day health care to eligible veterans. The reorganization will improve consistency and clarity throughout these State home programs. We propose to revise the regulations applicable to adult day health care programs of care so that States may establish diverse programs that better meet participants' needs for socialization and maximize their independence. Currently, we require States to operate these programs exclusively using a medical supervision model. We expect that these liberalizing changes would result in an increase in the number of States that have adult day health care programs. We also propose to establish new regulations governing the payment of per diem to State homes providing domiciliary care to eligible veterans, because the current regulations are inadequate. Moreover, we propose to eliminate the regulations governing per diem for State home hospitals because there are no longer any State home hospitals. In general, this rulemaking is consistent with current regulations and policies, and we do not expect that these proposed rules would have a negative impact on State homes; rather, we believe that these proposed regulations would clarify current law and policy, which should improve and simplify the payment of per diem to State homes, and encourage participation in these programs.

DATES: Comments must be received on or before August 17, 2015.

ADDRESSES: Written comments may be submitted through www.Regulations.gov; by mail or hand-delivery to the Director, Regulation Policy and Management (02REG), Department of Veterans Affairs, 810 Vermont Avenue NW., Room 1068, Washington, DC 20420; or by fax to (202) 273-9026. Comments should indicate that they are submitted in response to "RIN 2900-AO88-Per Diem Paid to States for Care of Eligible

Veterans in State Homes." Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1068, Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420, between the hours of 8:00 a.m. and 4:30 p.m. Monday through Friday (except holidays). Please call (202) 461-4902 for an appointment. (This is not a toll-free number.) In addition, during the comment period, comments may be viewed online through the Federal Docket Management System (FDMS) at www.Regulations.gov.

FOR FURTHER INFORMATION CONTACT: Dr. Richard Allman, Chief Consultant, Geriatrics and Extended Care Services (10P4G), Veterans Health Administration, 810 Vermont Avenue NW., Washington, DC 20420, (202) 461-6750. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: Currently, VA pays per diem to State homes for three types of care provided to eligible veterans: nursing home care, domiciliary care, and adult day health care. The statutory authority for these payment programs is set forth at 38 U.S.C. 1741-43 and 1745. Currently, VA has regulations at 38 CFR part 51 that apply to the payment of per diem for nursing home care and 38 CFR part 52 that apply to the payment of per diem for adult day health care. Many of the sections in parts 51 and 52 are similar or identical. In particular, subparts A, B and C of both parts (which collectively concern procedural rules, recognition, and certification requirements for the payment of per diem) contain a great deal of redundancy. In some cases, we have regulations in parts 51 and 52 that have identical substantive effect, but we have unintentionally worded them differently. Subparts D of parts 51 and 52 set forth unique standards applicable to the recognition and certification of nursing homes or adult day health care programs (although both subparts D do contain some overlap).

In order to eliminate redundancy and clarify the procedures for recognition and certification of State homes, we propose this extensive rewrite and reorganization of parts 51 and 52. This rulemaking would remove part 52. Part 51 would be re-titled "Per Diem for Nursing Home, Domiciliary, or Adult Day Health Care of Veterans in State Homes," adding domiciliary and adult day health care to the title of part 51, which had formerly applied only to nursing home care. The regulations in subparts A and B of part 52 would be consolidated with similar regulations in part 51, and would be organized in

subparts A and B of part 51. Proposed part 51, subpart C, would include regulations governing payments and eligibility for all three types of care. These proposed regulations would supersede the regulations currently contained in 38 CFR 17.190 through 17.200, which pertain to the payment of per diem for hospital and domiciliary care in State homes. Therefore, we propose to remove §§ 17.190 through 17.200.

Subpart D of part 51 would continue to set forth the standards applicable to the payment of per diem for nursing home care.

The regulations in subpart D of part 52, concerning adult day health care programs, would be moved to a new subpart F of part 51, and would be revised to broaden the ability of State home adult day health care programs to operate in a manner that emphasizes participant independence over a strict medical model of care. There are currently only two State homes receiving per diem from VA for adult day health care, and we wish to increase the number of such homes throughout the country because we believe that such care is a viable and healthier alternative for veterans who otherwise would require nursing home care.

This rulemaking would also establish new regulations that set forth standards that State homes must meet to receive per diem for domiciliary care. The proposed standards would supersede all non-CFR policies that contain standards for VA payment of per diem for domiciliary care in State homes.

Moreover, the proposed rule is generally consistent with the current regulations on the payment of per diem for domiciliary care except as discussed below. In fact, much of the current guidance for domiciliary per diem is substantively similar to the rules already established for nursing home care and adult day health care in current parts 51 and 52, and therefore the general rules in proposed subparts A and B would apply equally to domiciliary care. The standards applicable to domiciliary care are proposed at subpart E. In other words, for purposes of regulatory organization, we propose to treat domiciliary care in the same manner that we would treat our other two State home programs.

We would also update the authority citation for part 51 to include 38 U.S.C. 1745, which pertains to State home nursing home care for certain veterans with service-connected disabilities and was enacted after we published part 51. We have not yet updated the authority citation for all of part 51 to include 38 U.S.C. 1745, though certain sections

were updated to include a citation to it. This amendment would have no substantive effect but would clarify that it is one of VA's authorities for all of part 51.

A detailed discussion of the proposed revised part 51 follows, organized by subpart and section.

Subpart A—General

51.1 Purpose and Scope of Part 51

Section 51.1 would describe the purpose, scope, and organization of part 51.

51.2 Definitions

Section 51.2 would set forth definitions applicable to terms used throughout part 51. Definitions of terms that are currently defined in § 51.2 are unchanged, except where the same term was technically (but not substantively) defined differently in current § 52.2 such that minor technical revision was required. Definitions in current § 52.2 would be added to § 51.2 without substantive change, except as noted below. Also, we would adopt the regulatory definition of domiciliary care in 38 CFR 17.30(b) that currently applies to State homes in proposed § 51.2 except that the proposed definition would not include “travel and incidental expenses pursuant to § 17.143” because State homes are not required to pay these expenses pursuant to § 17.143. Finally, a few new definitions would be added, as explained below.

Current § 52.2 does not define “adult day health care;” however, part 52 does establish standards applicable to State home adult day health care. Many States would like to use a model of adult day health care that emphasizes socialization and maximizes participant independence, but does not provide as much medical supervision or involvement as is generally required by current part 52. Therefore, we propose to amend the regulations governing State home adult day health care to allow for flexibility and to establish standards of medical care only when the State home provides such care. These revisions are discussed in greater detail in the portion of this notice describing proposed subpart F of part 51. In § 51.2, we would set forth a definition of adult day health care that will allow for flexibility in terms of the services provided. As revised, this type of adult day health care program would serve as an alternative to full-time nursing home care; it emphasizes group activities and is designed to reduce or postpone the need for institutional placement (such as placement in a nursing home), rather

than emphasizing medical treatment. We believe that these proposed revisions will expand the availability of adult day health care within State homes and for veterans who wish to live at home but who require daily care, and may lead to decreased demand for costly nursing home care. As such, we believe that this would produce a positive result for veterans.

We note that current 38 CFR 17.111(c)(1) defines “adult day health care” for the purposes of a copayment determination for adult day health care provided by VA. This regulation does not apply to the State home program. However, VA is currently considering whether the expanded definition of adult day health care that would apply to State homes under this rulemaking should also apply to VA adult day health care. Any revisions to part 17 would appear in a separate rulemaking.

We will not provide different rates of payment to State home adult day health care programs that provide intensive medical supervision and those that do not. Adult day health care provided under the current definition is typically more expensive than what States could offer using the broader definition of adult day health care programs proposed in this rulemaking; however, current State participation in adult day health care for veterans is virtually nonexistent due to this higher cost. In part because current VA requirements are too expensive to implement, we are proposing these revisions in an effort to expand State home adult day health care as an option for our veterans.

We propose a definition of clinical nurse specialist that accords with the intended meaning of the term for all these State home programs. Currently, both parts 51 and 52 require that a clinical nurse specialist be “a licensed professional nurse with a master's degree in nursing and a major in a clinical nursing specialty from an academic program accredited by the National League for Nursing.” However, current § 51.2 also requires that the nurse be “certified by a nationally recognized credentialing body (such as the National League for Nursing, the American Nurses Credentialing Center, or the Commission on Collegiate Nursing Education).” We no longer believe that such certification is necessary in order for a nurse to be qualified, which is why we had dropped that additional language when we promulgated part 52. Therefore, in these new regulations, we would also drop the additional language from the rules that apply to nursing home care.

We would establish that references to “Director” in this part would be to the

Director of the VA medical center of jurisdiction, unless the section specifically refers to another type of director. This is a nonsubstantive change that is intended to clarify references in the regulations.

Current § 17.30(b) defines “domiciliary care” for the purposes of VA's “medical regulations,” *i.e.*, current part 17. VA's current regulations for payment of per diem to state homes for domiciliary care are part of those regulations. Therefore, this definition applies to the State home program. We propose adopting a similar definition of domiciliary care in § 51.2, except that we would update the language and delete the requirement that State home domiciliaries provide “travel and incidental expenses pursuant to § 17.143,” which previously was the regulation implementing VA's authority to pay beneficiary travel of certain veterans. VA's current beneficiary travel regulations are set forth in 38 CFR part 70, and they generally require VA to pay for eligible Veterans' travel to and from VA facilities. In any case, those regulations only require VA to pay for travel; they do not apply to State homes. We thus propose to not require State homes to pay for travel in the same manner as VA does under VA's beneficiary travel program. We also propose to remove the requirement that State home domiciliaries provide residents with clothing. Although VA is required by 38 U.S.C. 1723 to provide clothing under certain circumstances in its own facilities, this statute does not apply to State homes. VA erroneously included provision of clothing in the current regulation.

We would add a definition of “[e]ligible veteran.” The term would refer to a veteran whose care may serve as a basis for per diem payments. The definition would reference the substantive sections under which such eligibility would be established for each of the three per diem programs.

We would eliminate the current definition of “facility” in §§ 51.2 and 52.2 because it is not necessary. We would add a definition of “licensed medical practitioner.” The term would encompass and would refer to the following terms we further define in this section: Nurse practitioner; physician; physician assistant; and primary physician or primary care physician.

We would revise the definition of “nursing home care” to be consistent with the statutory definition of that term in 38 U.S.C. 101(28).

We would define “participant” as an individual receiving adult day health care and “resident” as an individual receiving nursing home or domiciliary

care. The proposed definitions would be consistent with the uses of those terms in both the current regulations and the proposed regulations.

The last sentence of the definition of “physician assistant” in current § 51.2 states that a physician assistant must be able to perform certain tasks “under appropriate physician supervision which is approved by the primary care physician.” The last sentence of the same definition in § 52.2 states that a physician assistant must be able to perform the same tasks “under the appropriate supervision by the primary care physician.” Thus, part 52 requires actual supervision by the primary care physician, but part 51 does not. We did not intend these provisions to be different, and would require in revised § 51.1 that the physician assistant be able to perform such tasks “under appropriate physician supervision.” This would allow clinicians to determine on a case-by-case basis what level of supervision is required.

We would define a “program of care” as any of the three levels of care for which VA may pay per diem under part 51. Current regulations use this term, and it is convenient to retain it.

We would revise the definition of “State,” which currently includes “possessions of the United States.” Although this definition is consistent with the definition in 38 U.S.C. 101(20), the definition of State home, in 38 U.S.C. 101(19), does not include a home established in a possession of the United States. Because the definition of State in part 51 applies only to part 51, and we are not authorized to provide per diem to State homes in possessions of the United States, we would delete the reference to possessions in the definition of “State.” This is a substantive change; however, it has no actual impact because there are not any State homes established in a possession. Also, we are not aware that any possessions have permanent populations that would justify the establishment of a State home.

The statutory definition of “State” includes “Territories” of the United States. 38 U.S.C. 101(20). The Department of the Interior, which has administrative responsibility for coordinating federal policy in Island groups in the Insular Area, has identified the United States Virgin Islands, Guam and American Samoa as territories of the United States, and the Northern Mariana Islands as a Commonwealth in Political Union with the United States, which is treated as a U.S. territory for purposes of the State home per diem payment program. See VAOPGCCONCL 10–98 and

VAOPGPCPREC 55–91. We thus propose to amend the definition of “State” to include the Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa. The Commonwealth of Puerto Rico would remain part of the definition. The proposed revisions would make this definition of “State” consistent with the definition of “State” for purposes of the program that provides grants to States for construction and acquisition of State homes. See 38 CFR 59.2. Because this proposed definition of “State” would name each of the included territories of the United States, we propose to delete the reference to “territories” in the definition.

We would revise the current regulatory definition of “State home” to eliminate the reference to hospital care because we no longer pay per diem for hospital care through the State home per diem program. This is also an important reason to eliminate current 38 CFR 17.190–17.200 which concern in part payment of per diem for hospital care in State homes.

We would define a “veteran” as a veteran under 38 U.S.C. 101.

We would not include from current § 52.2 the definition of “instrumental activities of daily living” because the term would not appear in part 51. It is no longer necessary to the adult day health care program, and is not used in the administration of nursing home care or domiciliary care. Changes to the adult day health care program are further explained below.

Subpart B—Obtaining Recognition and Certification for Per Diem Payments

Subpart B would establish the procedures for obtaining State home recognition and certification, in order to receive per diem payments. These procedures would be common to all three programs, except as specifically noted in the proposed regulations. We propose to remove current § 51.10, because it is unnecessary and merely restates information that is set forth in more detail in other sections of subpart B. Despite the removal of § 51.10, we would keep the section numbering in subpart B the same, or reasonably similar, to the current numbering.

51.20 Recognition of a State Home

Section 51.20 is based on current regulations governing the recognition and certification process, but the proposed rule would establish clearer and simpler procedures, without making significant substantive changes to the current process. We discuss the proposed process in detail below.

A key difference in the new process is that the current process requires both recognition and “initial certification” by the Under Secretary for Health for State home nursing homes and adult day health care programs, but does not clearly distinguish between the requirements for recognition versus the requirements for initial certification. Moreover, “initial certification” is no different from the ongoing annual certification, except that “initial certification” is provided by the Under Secretary for Health while annual certifications are authorized by the Director of the VA medical center of jurisdiction. It is confusing to have the same decision, certification, be authorized by two different individuals, particularly because the annual certification is then appealable to the Under Secretary for Health. Therefore, the proposed process would refer to the initial determination by the Under Secretary solely as a “recognition” determination, and all subsequent determinations (other than those following revocation) as “certifications.” We emphasize that this change would not affect the State homes themselves, because current regulations require State homes to follow all applicable regulations in order to obtain recognition and initial certification as well as annual certification. We believe that it is clearer to distinguish recognition, which requires the Under Secretary for Health’s approval, from certification, which requires only approval at the level of the Director of the VA medical center of jurisdiction. Another significant change is the delegation to the Under Secretary for Health for all recognition and appeal decisions related to domiciliaries. We believe it is more appropriate for the Under Secretary, who has direct responsibility for the provision of health care by VA, to make such decisions. This difference, and any other differences between the current regulations in part 17 regarding State homes and proposed part 51, would be resolved by this rulemaking for the policy reasons set forth in this rulemaking.

In current § 51.20(a), we require that requests for recognition be sent to the Chief Consultant, Office of Geriatrics and Extended Care (114). The Veterans Health Administration (VHA) recently changed its management structure, so that the Director of the Office of Geriatrics and Extended Care Operations now performs the management and operations duties for State homes that were formerly performed by the Chief Consultant of

the Office of Geriatrics and Extended Care. The proposed rule would change references to the "Chief Consultant" to the "Office of Geriatrics and Extended Care" in § 51.20(a). We make the same change in proposed §§ 51.120(a)(3) and 51.210(b). VHA will publish policy documents to inform State homes of the addresses to which any documents must be mailed.

Current §§ 51.20 and 52.20 require that the request for recognition be signed by "the State official authorized to establish the State home." State homes are often established through acts of the State legislature. Therefore, we would revise the language to require signature by "the State official authorized to make the request." This is in fact how the current process works, so this revision would merely be a clarification. Current § 17.191 requires that applications for recognition of State home domiciliaries be filed with the Under Secretary for Health and provides that the Secretary of VA will make the final decision after considering a recommendation from the Under Secretary for Health. As noted above, the proposed rules would delegate recognition authority to the Under Secretary for Health. In addition, proposed § 51.20 would make the process of requesting and obtaining recognition of a State home domiciliary otherwise consistent with the process applicable to State nursing homes and adult day health care programs. There is simply no longer any reason to support using different procedures.

Proposed § 51.20(b)(1) would state that after receiving a request for recognition under § 51.20(a), VA will survey the home in accordance with § 51.31. This is consistent with current practice governing domiciliaries and with current §§ 51.30 and 52.30. Paragraph (b)(1) would also provide that in surveying the home VA must determine if the home meets the standards set forth in this Part and that those standards which impose requirements on State homes would apply to homes that are being considered for recognition. This is necessary because proposed § 51.2 defines "State home" as a home that has already been recognized by VA.

Paragraphs (b)(2) and (3) would require the Director to submit to the Under Secretary for Health a written recommendation for or against recognition. Proposed paragraph (b)(3), concerning recommendations against recognition, is based on parallel provisions in the current regulations; however, we would revise the description, currently in §§ 51.30(a)(2) and 52.30(a)(2), of the State's rights in

a case where the Director does not recommend recognition. The current regulations provide that the State may appeal such recommendation to the Under Secretary for Health; however, the Director is not authorized to award recognition and therefore the Director's recommendation has no direct adverse effect on the State. The Director's recommendation carries no legal effect, and merely serves as evidence considered by the Under Secretary for Health. Therefore, it would be incorrect to characterize the State's response to this recommendation as an appeal. At the same time, the Director's recommendation may influence the Under Secretary for Health's determination on the recognition request, and therefore the State should have an opportunity to present evidence to the Under Secretary for Health to support a decision that is contrary to the Director's recommendation. Thus, we would explain that the State must be afforded 30 days to submit a response and any additional evidence to the Under Secretary for Health.

In proposed paragraph (c), we would clearly state that the Under Secretary for Health's decision may be appealed to the Board of Veterans' Appeals. This is consistent with current law and practice and current § 51.30(f), but is not clearly stated in our regulations governing per diem for State home domiciliaries and adult day health care programs.

In addition, current § 52.30(a)(1) requires the Director to make a "tentative determination" regarding recognition and certification, while current § 51.30(a)(2) requires the director to make a "recommendation." The latter is more accurate, and § 51.30 would accordingly refer throughout to a "recommendation."

Proposed § 51.20(d) is based on the last sentences of current §§ 51.30(b) and 52.30(b). Paragraph (d)(1) would clarify that recognition of a home means that the State home met all applicable requirements of part 51 at the time of recognition. Paragraph (d)(1) would also indicate, for purposes of clarity, that certification must thereafter be obtained no later than 450 days after the home is recognized and every 450 days thereafter, in accordance with § 51.30(b).

Proposed paragraph (d)(2) would state that "any new annex, new branch, or other expansion in the size of a home or any relocation of the home to a new facility must be separately recognized." This is consistent with current practice and §§ 51.30(b) and 52.30(b). We also propose in paragraph (d)(2) a substantive change to the current requirements, which would be that

"changes in the use of particular beds between recognized programs of care and increases in the number of beds that are not described in the previous sentence require certification of the beds, but not recognition." This means that a State with a recognized domiciliary and nursing home may change the use of one or more beds in the domiciliary to nursing home care without requesting recognition from the Under Secretary for Health. A survey would still be required, but only certification by the Director would be needed. This would allow State homes to change the uses of beds without going through the cumbersome recognition process and at the same time would enable VA to ensure that the State home meets the applicable standards of care and can adequately meet the needs of the new residents assigned to those beds.

We note that current §§ 17.190 through 17.193 impose several requirements regarding recognition and certification of State home domiciliaries. Some of these requirements are similar to the requirements in this Notice of Proposed Rulemaking, but others conflict. For example, current § 17.192 provides that separate applications for domiciliary recognition must be filed for any annex, branch, enlargement, expansion, or relocation of a recognized home that is not on the same or contiguous grounds on which the parent facility is located. But proposed § 51.20(d) would require a separate application for recognition of any such change, regardless of whether the change would be made on the same or contiguous grounds. This is necessary to ensure that the facility continues to meet the standards applicable to domiciliaries. It is also consistent with the manner in which VA handles similar applications in the nursing home or adult day health care contexts.

51.30 Certification

Proposed § 51.30 is based on the annual and provisional certification requirements in current §§ 51.30 and 52.30. Although the recognition process proposed in § 51.20 is similar to the current process, we propose significant simplifications and changes to the certification process that will improve VA's ability to authorize programmatic changes and allow State homes greater flexibility in meeting the needs of their resident populations.

Proposed paragraph (a) would state that State homes must allow a VA survey of the home in order to be certified by VA. It would also state that a State home must be certified within 450 days after the State home is

recognized and that certifications expire 600 days after they are issued. This would ensure that VA has sufficient time to survey and recertify State homes if certification is warranted. This provision is based on current §§ 51.30(c) and 52.30(c), with clarifications due to the proposed simplified certification procedures.

Proposed § 51.30(b)(1) would state that the Director of the VA medical center of jurisdiction would certify a State home based on a survey conducted at least once every 270–450 days, at VA's discretion, and would require the Director to notify the State home of a certification decision within 20 days of the decision. Twenty days is sufficient time for VA to ensure notification, and is comparable to the time periods required for other actions under this rulemaking. See proposed § 51.30(c)(1)(iii). Requiring a periodic survey is entirely consistent with current regulations and practice as to all three programs of care.

Proposed paragraph (c) would revise VA's current certification procedures to make it easier for a State to change the size of a recognized program of care. Under current regulations, changes to the size of a program of care require a new recognition decision.

In proposed paragraph (c)(1), we would require only a new survey and certification decision when an existing State home increases the number of available nursing home or domiciliary beds in a recognized program of care, except increases described in the first sentence of § 51.20(d)(2), or when a State home recognized to provide both domiciliary and nursing home care switches beds between recognized programs of care. The proposed regulations would allow the Director to precertify, at the request of a State home, the increased number of beds or beds switched between recognized programs of care in an existing State home so that payments can be made for care of eligible veterans in these beds during the certification survey process for up to 360 days or until VA issues a certification decision, whichever occurs first. We would provide that precertification would be authorized if the Director reasonably expects, based on prior surveys and any other relevant information, that the State home would continue to comply with part 51 until the State home is surveyed and certified. We would also provide that VA would pay per diem for the care of eligible veterans in the beds provided on and after the date the Director precertifies the beds. Permitting precertification would allow VA to

provide guidance to the State home in advance of VA's certification survey.

In proposed paragraph (c)(2), we would require the State to report to the Director any decreases in the number of beds available and an explanation of such decrease within 30 days. Currently, 38 CFR 51.30(b) requires certification when a State home reduces the number of beds, and we do not believe that it is a good use of resources to require VA, or the State home, to go through the certification process in such cases. Thus, under paragraph (c)(2), decreases in size would be explicitly exempted from requiring certification.

Proposed paragraph (d) would govern the provisional certification process. Paragraph (d)(1) would require the Director to issue a provisional certification under specified circumstances. This is mostly consistent with current practice. We would require that the State's corrective action plan be submitted to the Director no later than 20 days after receipt by the State home of the survey report. If the State does not submit a corrective action plan within 20 days, the Director would not issue a provisional certification. Twenty days is a reasonable amount of time, particularly because proposed § 51.30(b) would require VA to provide a copy of the survey report within 20 days after the survey is completed. We would provide that the Director must determine that the corrective action plan is reasonable. We would also require the Director to send written notice to the appropriate person(s) at the State home informing them that the Director agrees with the plan.

The current regulations recommend that certifications, including provisional certifications, should be made every 12 months. But they do not address how a provisional certification of more than 12 months would affect the annual certification requirement. This can be confusing. Therefore, proposed paragraph (d)(2) would clarify that VA will continue to survey the State home while it is under a provisional certification in accordance with proposed §§ 51.30 and 51.31, and will continue the provisional certification so long as the criteria for issuing the initial provisional certification, listed in proposed paragraph 51.30(d)(1), remain true. This means that if new deficiencies are identified during an annual survey, then a new provisional certification (or denial of certification) would be required as to those new deficiencies.

Proposed paragraph (d)(3) would clarify what happens if a State home fails to adhere to the corrective action plan. In such instances, we would no longer make issuance of a provisional

certification mandatory, but would allow the Director the discretion to issue another one if the State submits a new written plan to remedy each remaining deficiency within a reasonable time. The new written plan must be submitted no later than 20 days after the expiration of the time specified to remedy all deficiencies in the original plan, which VA has determined is a reasonable time to develop a plan to remedy any remaining deficiencies. This would enable a case-specific approach, so that State homes that have made efforts to correct problems and that otherwise provide important services to veterans can continue to receive per diem, but VA would not be required to fund State homes that, in the Director's view, have not shown either the ability or willingness to correct problems. Under paragraph (e), the State home would have the right to appeal the Director's decision not to issue an additional provisional certification, which is described in more detail in the discussion of proposed § 51.30(e) that follows.

Proposed § 51.30(e) is based on current § 51.30(a)(2), (d), (e), and (f), and parallel provisions in current § 52.30. Although the information on notice and the right to appeal is reorganized, it is not substantively different, except as noted below.

First, in § 51.30(e), we would eliminate any implied right to appeal provisional certifications. These certifications have no adverse effect on the State, and, indeed, the State must agree to correct any deficiency before VA would issue a provisional certification. Therefore, there is no need to appeal provisional certifications.

In proposed § 51.30(e)(1) through (3), we would clearly set forth the review and appeal procedures for a decision by VA not to issue a certification of a State home. Currently, VA delegates the annual certification process to its local VA medical center Directors—unlike the recognition decision, which is made by the Under Secretary for Health. Therefore, an appeal from the Director's decision includes review by the Under Secretary for Health. The proposed rule is consistent with current practice. Also consistent with current practice, we would explain in paragraphs (e)(1) and (e)(2) that per diem payments will continue during the appeals process. Finally, we would state in § 51.30(e)(3) that a denial of certification may be appealed to the Board of Veterans' Appeals only if it results in a loss of payments to the State, and that VA would discontinue payment of per diem if the Under Secretary for Health affirms the Director's decision. The current

regulation at § 51.30(f) allows States to appeal any denial of certification to the Board of Veterans' Appeals. VA proposes this change because deficiencies at a State home that do not result in a loss of per diem payments are best remedied through a written plan and corrective actions, as required by proposed paragraph (d). Under the proposed rule, VA would terminate payments on the date of a decision affirming the denial of certification, or on a later date specified in the decision by the Under Secretary for Health, which allows the Under Secretary to accommodate State homes that lose certification while providing care to veterans.

Proposed § 51.30(f) would state that appeals of all other matters will be governed by VHA's appeals regulations in 38 CFR part 20.

Current § 51.31, "Automatic recognition," was essentially a grandfather clause allowing those State homes recognized by VA at the time that part 51 was promulgated in 2000 to maintain their recognition, but requiring them to be certified annually. There is no need to maintain this provision because all such State homes have been "grandfathered in." We therefore propose to remove this section.

51.31 Surveys for Recognition and/or Certification

Proposed § 51.31 concerns surveys, and applies to both the first VA survey for recognition and surveys for certification. Paragraph (a) is based on current §§ 51.30(c) and 52.30(c), except as noted below.

VA routinely conducts annual surveys without advance notice, but VA always provides advance notice before the recognition survey is conducted. In fact, for recognition surveys VA wants the home to be fully prepared so that VA can determine whether it has the capability to meet the applicable requirements. Accordingly, proposed § 51.31(a) would indicate that VA will provide advance notice before a recognition survey, and may notify the State before other surveys. This is a substantive change to both parts 51 and 52 that should improve the ability of State homes to prepare for VA recognition surveys.

Current VA regulations (§§ 51.30(c) and 52.30(c)) provide that a survey will cover all parts of a nursing home or adult day health care facility. There are times, however, when VA needs to survey only part of a home. For example, if a recognition survey finds that a home does not meet several standards, the State may request another VA survey after fixing those

deficiencies. VA believes that only a survey of that part of the home that would permit a determination as to whether the standards have been met would be necessary. Accordingly, § 51.31(a) would permit surveys to cover all parts of a home or only certain parts.

In the last sentence of proposed paragraph (a), we would permit the Director to designate VA officials and/or contractors to survey a home. The designation of contractors is not specifically authorized by the current regulations, but it reflects the modern way in which VA conducts these surveys. The use of contractors, rather than local VA employees, is one way in which VA attempts to ensure that surveys across the country are conducted in a timely and similar manner. Moreover, we would eliminate the current language stating that the surveying team "may include" certain listed professionals (*i.e.*, physicians, nurses, fiscal officers, etc.), because the language is hortatory and because we have found that the use of specifically trained contractors has, in most cases, eliminated the need to include some of these professionals.

Proposed § 51.31(b)(1) would establish the minimum occupancy threshold required before VA will conduct a recognition survey of a domiciliary. We would require that a domiciliary have at least 21 residents or a number of residents consisting of at least 50 percent of the resident capacity of the domiciliary before VA will undertake a survey. This is the same requirement for nursing homes which is in current § 51.30(a)(1) and which we propose including in this paragraph. Proposed § 51.31(b)(2) would establish the minimum participation threshold required before VA will conduct a recognition survey of an adult day health care program. For an adult day health care program of care, we would require that it have at least 10 participants or a number of participants consisting of at least 50 percent of participant capacity. We believe that this is the minimum participant capacity necessary for VA to determine whether the program is able to meet the applicable standards. We also note that the current rule applies the occupancy requirement to "new" nursing homes. By "new," we intended to refer to homes that have not previously been recognized, but did not intend the requirement to apply only to new construction. We would remove the word "new" because it is unnecessary and potentially ambiguous. No substantive change is intended.

Proposed § 51.31(c) is based on current §§ 51.30(g) and 52.30(g), without substantive change.

51.32 Terminating Recognition

As noted above, proposed § 51.32 is based on the first sentence of current §§ 51.30(b) and 52.30(b). VA would terminate recognition of a State home if the State requests that VA terminate it or if VA makes a final decision not to certify the State home.

Subpart C—Eligibility, Rates, and Payments

51.40 Basic Per Diem Rates

Proposed § 51.40 would set forth the basic method for calculating the basic per diem payment rate, and establish that this method is the same for all three programs. The per diem rates would be calculated in the same manner as they are in the current regulations, but technical aspects of the rules on per diem rates are outdated or in need of revision and would be updated.

First, current § 17.197, applicable to domiciliary care, indicates that VA will publish the actual per diem rates, whenever they change, in a **Federal Register** Notice. Proposed § 51.40 does not include this requirement because any State home providing domiciliary care would be given actual and timely notice of any changes in the per diem rates. Second, current § 52.40(a)(1), which applies to adult day health care, includes an outdated reference to the rate for fiscal year 2002. The current rule on basic per diem rates for nursing home care, at § 51.40(a)(2), is also outdated because it refers to the rate for fiscal year 2008. The rates are currently, and would continue to be, established in accordance with 38 U.S.C. 1741(a) and (c). We propose to make a more general statement, without reference to any particular fiscal year, describing how the basic per diem rate is calculated. This would ensure that our regulations do not become outdated within a year of publication.

Proposed § 51.40(b) would set forth VA's formula for calculating the daily cost of care of a veteran, which is consistent with current practice and regulation at § 51.43(e). We do not propose any substantive revisions to this formula for calculating basic per diem rates.

Paragraph (c) of proposed § 51.40 would incorporate current § 51.43(c), with minor clarifying changes to the paragraph, which was amended by the direct final rule published on September 27, 2012. 77 FR 59318, 59320, Sept. 27, 2012.

Proposed paragraph (d) would describe how to determine whether a

veteran has spent a day in an adult day health care program. Current § 52.40(a)(2) defines “a day” as “[s]ix hours or more in one calendar day; or . . . [a]ny two periods of at least 3 hours each (but each less than six hours) in any two calendar days in a calendar month.” A question has arisen regarding whether time spent in State-provided transportation between the veteran’s home and the State home, in transportation to a health care visit, or accompanied by State home staff during a health care visit, should be included as time a veteran received adult day health care. If adult day health care were not available to these veterans, they would need to leave their own residences for nursing home care, and therefore special State-provided transportation is an important part of their care. State homes offer most adult day health care program participants transportation to and from health care visits with drivers who are certified in basic life safety and can provide basic assessments, ambulation escorts, wheelchair lift services, and proper handoffs at the site of the health care visit. Transportation between the veteran’s residence and the State home includes door-to-door care. Therefore, to ensure continuity of care, we believe that time spent in transportation and accompanied by State home staff should be included as times that veterans receive adult day health care, and we propose to clarify paragraph (d)(3) accordingly.

51.42 Payment Procedures

Proposed § 51.42(a)(1) is based on current §§ 51.43(a) and 52.40(a)(5); proposed § 51.42(a)(2) is based on current §§ 51.43(b) and 52.40(a)(3); proposed § 51.42(b)(1) is based on current §§ 51.43(d) and 52.40(a)(4); proposed § 51.42(b)(2) is based on current §§ 51.43(d) and 52.40(a)(4). Proposed § 51.42(b)(3) is based on current §§ 51.43(a) and 52.40(a)(5). Slight differences between regulations in parts 51 and 52 have been corrected to accurately reflect the forms required under this section.

In proposed paragraph (a)(1), we would clarify that the forms required under the regulation must be submitted when a veteran is admitted to a State home (for State homes that have already been recognized and certified), or at the time of the recognition survey (for a home that a State has submitted an application for recognition as a State home).

In addition, we would clarify in paragraph (a)(2) that the VA Form 10–5588 must be submitted every month in order for VA to pay per diem for the

prior month. The proposed rule is also consistent with payment rules related to domiciliaries, at § 17.198, but provides greater clarity. Finally, we would add a statement to § 51.42(a)(1)(i) to clarify that nursing home applicants and residents and enrolled adult day health care participants do not need to complete the financial disclosure section of VA Forms 10–10EZ and 10–10EZR under certain specified circumstances, but domiciliary applicants and residents must do so, and adult day health care applicants may be required to provide financial information to enroll with VA.

In paragraph (b)(1), we would state that payments will not be made until the home is recognized, which is consistent with the current regulations, and that each veteran resident is verified as eligible for the program, which is not stated in the current regulations, but has been VA’s consistent practice, as VA may only pay for care provided to veterans who are eligible for the program.

In paragraph (b)(2), we would clarify that VA will make payments for care in beds certified or precertified under § 51.30(c) retroactive to the date of precertification of the beds and to the date of the completion of the survey if the Director certifies the beds as a result of that survey. The current regulations in §§ 51.43(d) and 52.40(a)(4) specify that VA will pay retroactive to the date of the completion of the recognition survey, but do not address precertification and certification of State home beds provided for in proposed § 51.30(c).

Proposed paragraph (b)(3) explains when VA would begin making payments or make retroactive payments based on the State home’s submissions of forms in accordance with the proposed rule. VA proposes to expand the current deadline to receive paperwork and begin per diem payments from 10 days to 12 days.

51.43 Drugs and Medicines for Certain Veterans

Proposed § 51.43(a) is substantively identical to current § 51.42(a); the only changes made were technical changes to conform to the proposed reorganization.

Proposed § 51.43(b) would reference the other authority for VA to provide drugs and medicines to veterans in a State home: 38 U.S.C. 1712(d), as implemented by § 17.96. Consistent with current § 51.41(c), this authority would be subject to the limitation in proposed § 51.41.

Proposed § 51.43(c) is based on current § 51.42(b). We propose to extend its application, however, to drugs and

medicines furnished under 38 U.S.C. 1712(d), as implemented by § 17.96. Requiring that VA furnish a drug or medicine only if the drug or medicine is included on VA’s National Formulary unless VA determines a non-Formulary drug or medicine is medically necessary should result in significant savings because, insofar as possible, the VA National Formulary consists of generic medications that often cost much less than brand medications. These are the same medications used for VA nursing home residents.

Proposed § 51.43(d) is substantively identical to current § 51.43(f). Most of current § 51.43 would be deleted and reincorporated into proposed § 51.40, but paragraph (f) deals specifically with payments for drugs and medicines, and therefore would be moved to proposed § 51.43. For consistency and to avoid confusion, we propose to require that States also submit a completed VA Form 10–0460 when requesting drugs for veterans eligible under § 17.96.

51.50–51.52 Eligibility

Proposed §§ 51.50, 51.51, and 51.52 would set forth the eligibility criteria that a veteran must meet in order for that veteran’s care to serve as a basis for a per diem payment under each of the three programs. The minimum periods of active duty service required in 38 U.S.C. 5303 and 5303A apply to all three programs of care; therefore proposed §§ 51.50, 51.51, and 51.52 would each state the requirement. The minimum service requirement is in the current adult day health care regulations at § 51.52, but was inadvertently omitted from the nursing home eligibility regulations in current § 51.50. Nevertheless, VA has enforced this provision, as required by law, and therefore this proposed rule does not impose a new limitation on eligibility. In addition, in these sections we adopt the interpretation of 38 U.S.C. 101(2) regarding the character of discharge required for the provision of VA benefits to veterans that is set forth in 38 CFR 3.12. The interpretation of 38 U.S.C. 101(2) regarding the character of discharge is adopted in order to be consistent with the interpretation adopted for purposes of other VA benefit programs.

Section 51.50 (nursing home care) is virtually identical to current § 51.50, except for the addition of the requirement regarding the character of the veteran’s discharge and certain other minor technical changes. We propose to add veterans who were awarded the Purple Heart or the medal of honor to the eligibility category in § 51.50(b) because these veterans are now eligible

by statute. See 38 U.S.C. 1705(a)(3), 1710(a)(2)(D). We propose to remove the provision regarding eligibility for veterans of the Mexican border period and World War I, because there are no living veterans of these eras. We also propose to add a note to § 51.50 to clarify that enrollment and eligibility to enroll in the VA health care system are not required for a veteran to be an “eligible veteran” for purposes of per diem payments. Finally, we propose to add veterans seeking care “for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as provided and limited in 38 U.S.C. 1710(e)” because these veterans are now eligible by statute. See 38 U.S.C. 1710(e)(1)(D), (e)(2)–(3).

Current § 17.194 provides that VA pays per diem for domiciliary care for veterans who are eligible for domiciliary care in a VA domiciliary. This is consistent with the statutory requirement in 38 U.S.C. 1741(a). However, we believe that it would be useful to the States and VA personnel for the regulation to set forth which veterans are eligible for domiciliary care in VA facilities. Eligibility for VA domiciliary care is set forth in §§ 17.46(b) and 17.47(b)(2). Proposed § 51.51 would thus describe the veterans who meet the requirements set forth in §§ 17.46(b) and 17.47(b)(2) and state that they are “eligible veterans” for the purpose of payment of per diem for domiciliary care in a State home.

Section 51.52 would set forth the criteria for determining whether a veteran’s care is eligible for per diem for adult day health care. Based on a statutory change to 38 U.S.C. 1720(f)(1)(A), a veteran is now eligible for adult day health care if the veteran is enrolled in the VA health care system and otherwise would require nursing home care. Accordingly, § 51.52 would reflect the new requirement.

In addition, we propose to include in paragraph (d) criteria that reflect the level of care required by a veteran who would benefit from adult day health care. These criteria are derived from current § 52.80, but have been modified (made less stringent) to encompass an alternative model in addition to the medical model required by current § 52.80. For example, the requirements in proposed paragraph (c) are identical to the requirements in current § 52.80, except that we would add criteria to address individuals who live alone in the community or who are determined by a VA licensed medical practitioner to need adult day health care services. These additional criteria should

broaden the potential adult day health care population to include others who could benefit from such care. In the regulation text, the medical model would be referred to as an adult day health care program that offers medical supervision. We are attempting to encourage States to provide adult day health care for our Nation’s veterans. For example, we would eliminate the requirement that the veteran be dependent in three or more instrumental activities of daily living (such as using a telephone, cooking, shopping, etc.), and instead require that the veteran be dependent in three activities of daily living (such as ambulation, eating, bathing etc.). This decreased dependency requirement reflects our desire to permit State homes to provide an alternative to the medical model of adult day health care and to increase the number of veterans who could qualify for this less-institutionalized form of care. This rationale explains the other changes from the current requirements, such as the elimination of the requirements of recent discharge from a nursing home or hospital and of significant cognitive impairment characterized by multiple behavior problems.

Proposed § 51.52(d) would allow VA to pay for adult day health care based on less severe disabilities than those for which veterans currently may be eligible. This change would expand the cohort of eligible veterans and assist in cultivating a broader spectrum of adult day health care programs, which would be consistent with the rest of this rulemaking.

51.58 Standards Applicable for Payment of Per Diem

Proposed § 51.58 is based on current §§ 51.60 and 52.60, without substantive change.

51.59 Authority To Continue Payment of Per Diem When Veterans Are Relocated Due to Emergency

Proposed § 51.59 is substantively identical to current § 51.59, which was promulgated on September 8, 2011, after having been published for public comment. See 76 FR 55570. A few minor, technical changes are included that would conform to this rewritten regulatory framework.

Subpart D—Standards Applicable to the Payment of Per Diem for Nursing Home Care

Subpart D would set forth the standards applicable to the payment of per diem for nursing home care. VA proposes to change the title of this subpart from the current title of

“Standards” to ensure clarity and aid readers in distinguishing between the new standards being set forth for domiciliary and adult day health care. These standards are currently set forth at §§ 51.70–51.210, and would not be changed by this notice of proposed rulemaking, except as noted below.

51.140 Dietary Services

Current § 51.140(d)(4) requires a State home to offer substitutes of similar nutritive value to residents “who refuse food served.” We propose to delete “who refuse food served.” We do not believe that residents should have to refuse food in order to be offered alternative choices. Residents should always have more than one option at meal time.

51.210 Administration

We would amend the current rule concerning administration of nursing homes, which we also propose to make applicable in whole to domiciliaries and in part to adult day health care programs. The amendment would require a State home to disclose to VA whenever there is a change in the State home’s director of nursing services, or any other individual who is in charge of nursing services. Such changes may have significant ramifications for a State home, and may also affect VA’s coordination of VA care with the care provided by the State home. Therefore, VA needs to be aware of the change. We note that most adult day health care programs do not offer nursing services; however, this paragraph would apply to those that do. Thus, the proposed change would require those adult day health care programs that have a person in charge of nursing services to notify VA when such person changes.

VA proposes to add a new paragraph (h)(3) to clarify procedures for State homes to assist veterans who need health care that State homes are not required to provide under part 51. This provision would state that State homes may assist the veteran with seeking care from other sources, including VA. It would also state that if VA is contacted, VA would make a determination about the best way to provide the needed services and would notify the Veteran, or the authorized representative, of that decision. This is consistent with the manner in which VA currently handles these situations, and ensures that veterans receive all needed health care.

Subpart E—Standards Applicable to the Payment of Per Diem for Domiciliary Care and Subpart F—Standards Applicable to Adult Day Health Care Programs of Care

Subpart E would provide the standards for domiciliary care. As we have noted throughout this notice, these standards would supersede all existing regulations, directives, handbooks, or other statements of policy to the extent that some might be read to conflict with these proposed regulations. Subpart F would be based on current part 52, subpart D (current §§ 52.60 *et seq.*). Several sections in current part 52, subpart D, were intended to be (or are) identical to sections in current part 51, subpart D. Rather than restate identical requirements, we would simply refer the reader to the current part 51 section. We believe that this would simplify the process and help all parties concerned—residents, their families, State staff, and VA surveyors—understand where identical requirements are intended. However, there may be a few examples where we have restated the requirements rather than cross-reference them—this was done for ease of use.

We would do the same when identical standards apply to domiciliary care in subpart E, for which we do not currently have detailed regulatory standards.

Finally, we would remove several sections from subpart D of part 52, without proposing parallel sections in part 51. First, we propose to remove § 52.61 without establishing a similar provision in subpart F. Current § 52.61, “General requirements for adult day health care program,” describes a program requiring medical supervision, which is cost prohibitive for many States. Thus, there are currently only two adult day health care programs in the nation. We are restructuring program guidelines to provide States an opportunity to establish a range of adult day health care programs that reflect the needs of the local veteran population. Many States have expressed an interest in establishing adult day health care programs under these proposed new guidelines. More adult day health care programs would help VA support the provision of non-institutional care to veterans who might otherwise be forced into a nursing home in order to receive adequate care. Our goal is to increase participation in these non-institutional programs.

51.300 Resident Rights and Behavior; State Home Practices; Quality of Life

Proposed § 51.300 would state that States must protect and promote the rights and quality of life of participants

in domiciliary programs of care, as they do for residents in State nursing homes. We would thus require domiciliary programs of care to comply with § 51.70, 51.80, 51.90, and 51.100.

51.310 Resident Assessment

The proposed rule is based on current § 51.110. However, different specific requirements would apply in paragraphs (b) through (d) because under § 51.110(b)(1)(i), which would not be revised by this rulemaking, the assessment tool for nursing homes is a nationally published tool, the Resident Assessment Instrument/Minimum Data Set. No such tool exists for domiciliaries or adult day health care programs. The requirements that would apply under the proposed rule are currently used by VA in assessments of State home domiciliary and adult day health care programs of care. We welcome comments on these provisions, but expect that they will be familiar to the affected State homes.

51.320 Quality of Care

Proposed § 51.320 is based on current § 51.120, which describes quality of care standards for State home nursing home residents; however, we would tailor the proposed regulation to the needs of the domiciliary care population, which is generally capable of a greater level of self-care than those in nursing homes. For this reason, the examples of “sentinel events” in paragraph (a)(2) are slightly different; however, the term is intended, and defined, to have the same meaning throughout part 51.

Paragraphs (d) through (f), (h) and (k) of current § 51.120 would not be included in the proposed rule because they pertain to medical issues that would not be presented by domiciliary residents. In proposed § 51.320(f), we would not include the references to “[p]arenteral and enteral fluids,” which is contained in current § 51.120(l)(2), “[t]racheostomy care,” which is contained in current § 51.120(l)(4), or “[t]racheal suctioning,” which is contained in 51.120(l)(5), because these services are not provided by domiciliaries.

51.330 Nursing Care

Proposed § 51.330 would describe the nursing care required in domiciliaries. What would be required would be similar to what is required in nursing homes, except that we would not require the same level of skilled nursing supervision, based on the lower level of care required by residents of domiciliaries. To be admitted, domiciliary residents must retain higher functional capabilities than a nursing

home resident, and therefore domiciliary residents require less skilled nursing care. Due to these key differences, we cannot simply adopt the standards applicable to nursing homes; therefore, we would modify them to meet the generally accepted needs of domiciliary residents. These standards are similar to the expectations currently placed on State home domiciliaries. We welcome comments on these provisions, but expect that they will not present a new burden to the affected State homes.

51.340 Physician and Other Licensed Medical Practitioner Services

We propose to establish that State homes must provide the necessary primary care for their residents. This is consistent with VA General Counsel Precedent opinion 1–2014 which is on the web at: <http://www.va.gov/OGC/docs/2014/VAOPGCPREC1-2014.pdf>. We also propose that when a resident needs care that is other than what the State home is required to provide under this subpart, the State home is responsible for assisting the resident in obtaining that care. This would allow State homes to refer veterans to VA and other outside providers for care that the State home is not required to provide. Under the proposed rule, we would require that a physician must “personally approve[] in writing a recommendation that an individual be admitted to a domiciliary.” We would also require that each resident “must remain at all times under the care of a licensed medical practitioner assigned by the State home.” This accommodates those homes that may utilize, in addition to primary care physicians, other practitioners who are licensed to practice medicine. We clearly define by title those professions to be considered licensed medical practitioners in proposed § 51.2. By requiring State homes to provide physician services as set forth in the proposed regulation, it would continue VA policy of not providing physician services for Veterans in State home domiciliaries because the State home has a duty to provide these services. See 38 CFR 17.30(b), 17.38(c)(5).

Proposed paragraphs (a) and (b) address the appropriate use and supervision of non-physician licensed medical practitioners. Under paragraph (a), we would require that “[a]ny licensed medical practitioner who is not a physician may provide medical care to a resident within the practitioner’s scope of practice without physician supervision when permitted by state law.” This would clarify that homes must ensure that residents receive appropriate medical supervision at all

times. Under proposed paragraph (b), when the licensed medical practitioner assigned to a particular resident is unavailable, we would require that the home ensure that another licensed medical practitioner be available to provide care to that resident. This would assist VA in providing a resident-centered approach to domiciliary care. It would also provide consistency between the level of care provided to veterans in State homes and in VA settings, in which we utilize supervised licensed medical practitioners.

Proposed paragraph (c) would define the scope of care expected to be provided by primary care physicians or other licensed medical practitioners to residents during visits. We would specify that the resident's total program of care be reviewed, to include medications and treatment, and that progress notes documenting each visit must be in writing, signed, and dated. We would also require that all orders be signed and dated.

Proposed paragraph (d) would mandate the frequency of primary care physician or other licensed medical practitioner visits. We would specify that the resident must be seen by the primary care physician or other licensed medical practitioner at least once every 30 days for the first 90 days after admission, and at least once a calendar year thereafter, or more frequently based on the condition of the resident. We believe this requirement would be sufficient to meet the needs of the resident population in these homes. It strikes an appropriate balance between providing needed medical care and the lower need for ongoing medical supervision of residents in domiciliaries.

Proposed paragraph (e) would mandate that the domiciliary provide or arrange for the provision of physician or other licensed medical practitioner services 24 hours a day, 7 days a week, in case of an emergency.

51.350, 51.390 Incorporation of Standards to State Home Domiciliaries

Proposed § 51.350 would apply VA's State nursing home standards for dietary, dental, pharmacy services, infection control, and the physical environment to State home domiciliaries. Proposed § 51.390 would apply VA's State nursing home standards for administration to State home domiciliaries.

51.400 Participant Rights

Proposed § 51.400 would state that States must protect and promote the rights of participants in adult day health care programs of care, as they do for

residents in State nursing homes. We would thus require adult day health care programs of care to comply with § 51.70 except for § 51.70(m) regarding the right of married residents to share a room when both live in the State home.

51.405 Participant and Family Caregiver Responsibilities

Section 51.405 would be based on current § 52.71, with minor technical and stylistic revision. Additionally, we would revise the introductory paragraph to permit the adult day health care program to provide a copy of the statement of participant and family caregiver responsibilities "at or before the time of the intake screening." The current regulation requires that the copy be provided at the intake screening, which is too restrictive.

51.410 Transfer and Discharge

Section 51.410 is based on current §§ 52.80(b) and 52.210(p), with the substantive changes noted below.

We would not include the requirement in current § 52.80(b)(2) that "[a]ll participants' preparedness for discharge from adult day health care must be a part of a comprehensive care plan." We do not maintain comprehensive care plans for VA-operated adult day health care programs. The State home must record information about a participants' discharge from an adult day health care program in the clinical record as described in § 51.410(c) and the participant must receive information about the discharge as described in proposed § 51.410(e).

Proposed § 51.410(a) also would not include a provision parallel to current § 52.80(b)(3), concerning the documentation by a primary physician that is required for a transfer and discharge. We would not include this requirement because the veteran's primary physician would generally not be on staff with the adult day health care program, and therefore would generally not have privileges to document notes in the program's clinical records.

Finally, we would incorporate current § 52.210(p) into this rule at proposed § 51.410(g) because it also concerns transfers.

51.411 Program Practices

Proposed § 51.411 would include those parts of current § 52.80 that are not included elsewhere. We would not include a provision parallel to current § 52.80(f) because we do not require VA-operated adult day health care programs to have caregiver support programs. The purpose of adult day health care is to

provide most or all of the services generally performed by caregivers.

51.415 Restraints, Abuse, and Staff Treatment of Participants

Proposed § 51.415 would apply to State home adult day health care programs the same requirements regarding the use of restraints and staff treatment of participants as apply to State home nursing homes.

51.420 Quality of Life

Section 51.420 would be based on current § 52.100, with minor revisions in paragraph (g). Current § 52.100(g)(3) states that the State home must provide private storage space for each participant sufficient for a change of clothes. We propose to require that each private storage space be capable of being secured with a lock for protection of the contents. Requiring a lock would ensure that whatever the participant stores in their private space (such as clothes, a wallet, or a purse) can be safely stored. Current § 52.100(g)(5) requires State homes to provide a clean bed for acute illness. We propose in § 52.420(g)(5) to require that the State home provide either a clean bed or a reclining chair.

51.425 Physician Orders and Participant Medical Assessment

Section 51.425 would restate current § 52.110, with a number of changes concerning physician orders and participant assessments. This section, among other things, is designed to ensure that appropriate plans of care are prepared and updated based on assessments.

Proposed paragraph (a) would restate the admission requirements in current § 52.110(b), with some changes. We would continue to require a medical history and physical examination of the participant, but would additionally require documentation of tuberculosis (TB) screening. Presently, VA requires the examination within a reasonable time of the resident's admission, not to exceed 72 hours following admission. We propose to require that the examination occur no earlier than 30 days before admission. The proposed changes to this section would ensure that State homes receive current information about veterans' conditions for the purposes of making determinations regarding admission, and would ensure that participants will not endanger themselves or others because of TB, which could easily spread in an adult day health care setting.

Proposed paragraph (b) would revise current § 52.110(c), with a proposed change to the method for conducting

assessments of participants. The current regulation requires that a comprehensive plan of care be developed from comprehensive assessments based on the Minimum Data Set for Home Care (MDS–HC) Instrument Version 2.0, August 2, 2000. The MDS–HC is not used in adult day health care programs because it requires more of an assessment than is necessary for participants in such programs. We propose to base assessments conducted under proposed paragraph (b) on the criteria stated in proposed paragraph (d), described below.

In proposed paragraph (c)(2), we would continue to require that each person who completes a portion of the assessment sign and certify the accuracy of that portion of the assessment in order to ensure accuracy and accountability for the assessment.

In proposed paragraph (d), we would require the State home to ensure that each participant has a care plan based on criteria VA developed to describe the issues that need to be addressed for participation in an adult day health care program. The criteria would be set forth under paragraph (d), and would ensure that participants receive appropriate care. Current § 52.110(e)(1) requires the State home to “develop” such a plan. We are changing the language to require that the participant have a plan rather than that the State home develop the plan because, in some cases, the plan may have been created before the participant entered into the State home’s program of adult day health care. The word “develop” in the current rule can be misread to require the State home to create a new plan, even when VA has already created one. Under the proposed paragraph (d)(1), the plan of care must include measurable objectives and timetables for meeting the needs identified in the assessment. With the simplified assessments this can and should be readily accomplished without the need for interdisciplinary teams that are required by the current regulations.

Proposed paragraph (e) is based on current 52.110(f), with no substantial changes.

51.430 *Quality of Care*

Section 51.430 would restate current § 52.120, with some significant changes. First, we would clarify in proposed § 51.430(a)(2) that a home must report only sentinel events that happen “while the participant is under the care of the State home, including while in State home-provided transportation.” It is not necessary for a program to report a sentinel event that did not occur while the veteran was under the care of the State home. Thus, to the extent that a

sentinel event—such as an attempted suicide or misuse of prescribed medication—may occur in the evening, the adult day health care program would not be required to report that event to VA. In proposed § 51.430(c), State homes would continue to be required to make counseling and related psychosocial services available to improve the mental and psychological functioning of adult day health care participants with psychosocial needs, as individuals in such programs often have, or are at risk for developing, psychosocial problems. We would update the phrasing of this requirement to make clear the types of services that State homes must provide. Other paragraphs in § 51.430 of the proposed rule are identical to current § 51.210, and would reference that section.

Current § 52.120(c) through (f) and § 52.120(k) set forth requirements concerning vision and hearing, pressure ulcers, urinary and fecal incontinence, range of motion, accidents, nutrition, hydration, unnecessary drugs, and antipsychotic drugs in adult day health care programs of care. We propose to remove these provisions because they are not pertinent to care at a State home providing adult day health care.

51.435 *Nursing Services*

Current § 52.130 would become § 51.435, and the last sentence of paragraph (a) of the current rule would be removed. That sentence recommends that duty nurses be geriatric nurse practitioners or clinical nurse specialists. We propose to remove this recommendation because this level of specialty is not necessary for an adult day health care program. Because there is no collection of information associated with this regulation, we propose to remove the OMB control number that appears in current § 52.130 from proposed § 51.435.

51.440 *Dietary Services*

Proposed § 51.440 would apply to State home adult day health care programs the State nursing home standards for dietary services.

51.445 *Physician Services*

Proposed § 51.445 would be based on current § 52.150, which sets standards for physician services in adult day health care. The first two sentences of the current rule require that adult day health care participants “obtain a written physician order for enrollment” and “remain under the care of a physician.” This would be required in the proposed rule, irrespective of the level of medical supervision provided in the State home adult day health care

program. The requirement that participants remain under the care of a physician would not impose a staffing burden on State homes because the veterans would be enrolled in the VA health care system, and therefore many would be under the care of a VA physician. A physician must approve a veteran’s participation in an adult day health care program in the written order for enrollment and, moreover, must indicate whether there are medical needs that would require placement in an adult day health care program that offers medical supervision.

However, the level of involvement of the State home adult day health care program in the participant’s medical care depends on whether the program of care offers medical supervision. Therefore, we propose changes to paragraphs (a), (b) and (c) of the current rule text to indicate that they only apply if the program of care offers “medical supervision.” If medical supervision is offered, physician supervision and review must be appropriate to the level of care required by the participant.

We propose to revise the language of current § 52.150(d) to clarify that the program management need only ensure that participants are able to obtain emergency care when necessary. This requirement could be met if the program management called 911 on behalf of the participant. States may provide emergency care if they desire, but they would not be required to do so.

51.450 *Specialized Rehabilitative Services*

Current § 52.160, which sets standards for specialized rehabilitative services in adult day health care, would become proposed § 51.450. We note that unlike current § 52.150 and proposed § 51.445, no adjustments to the current language are required. This rule would apply only where the participant’s individualized care plan requires the provision of specialized rehabilitative services. If a State home does not have the capability to provide specialized rehabilitative services, it would not accept a veteran with such needs for placement in its adult day health care program. Because there is no collection of information associated with this regulation, we propose to remove the OMB control number that appears in current § 52.160 from proposed § 51.450.

51.455 *Dental Services*

Current § 52.170, which sets standards for dental services in adult day health care, would become proposed § 51.455. We propose minor changes to the current language so that

this regulation would apply only to State homes that offer an adult day health care program with medical supervision.

51.460 Administration of Drugs

Current § 52.180, which sets standards for administration of drugs in adult day health care, would become proposed § 51.460. We propose minor changes to the current language so that this regulation would apply only to State homes that offer medical supervision in their adult day health care programs.

51.465 Infection Control

Proposed § 51.465 would apply the State nursing home standards for infection control to State home adult day health care programs.

51.470 Physical Environment

Proposed § 51.470 is based on current § 52.200, with the following revisions.

First, current § 52.200 requires State homes to meet certain standards established in outdated editions of the National Fire Protection Association (NFPA) code. However, current § 51.200 cites more recent editions of the standards. We propose to merely cross-reference the § 51.200(a) requirement in § 51.470, to clarify that the same fire-safety standards apply to adult day health care programs, except that those provisions that only apply to nursing homes would not apply. In this manner, we would ensure that adult day health care programs and nursing homes are required to comply with the same edition of the appropriate NFPA publication. We note that most State homes must abide by the current versions of these standards in order to obtain appropriate permits and licenses from authorities other than VA.

In addition, current 38 CFR 52.200(b)(4)(v) requires a State home to have a quiet room with at least one bed, which functions to isolate participants who become ill or disruptive, or who require rest, privacy, or observation. We propose to change this requirement to permit the home to have either a bed or a reclining chair. We believe that this would satisfy the specified needs. Also, we would indicate that the purpose of the quiet room is for separation from other participants rather than isolation from other participants. This accomplishes the intended purpose without the connotation of restraint which often would not apply.

51.475 Administration

We would adopt all of the requirements of current § 51.210 except for those that do not apply to adult day

health care programs that do not provide medical supervision. We would update the authority citation to reflect VA's current adult day health care authorities.

51.480 Transportation

Current 38 CFR § 52.220 concerns the transportation of participants. Paragraph (b) specifies that the program management must have a transportation policy that includes routine and emergency procedures. The current regulation further states that a copy of the procedures must be located in all program vehicles. We propose to delete the provisions regarding the placement of the procedures in program vehicles. Instead, we propose to add language requiring that all such transportation (including that provided under contract) must be in compliance with the procedures. The goal is to achieve compliance, and we do not believe that it is necessary to impose requirements regarding the methods of obtaining compliance.

Current 38 CFR 52.220(c) requires that all vehicles transporting participants be equipped with a device for two-way communication. We propose revising this to clarify that the vehicle itself does not need to be equipped with the device. However, we propose to require that the driver have access to such a device. We also propose to revise this requirement to clarify that it only applies to State home-provided transportation, not transportation arranged by the veteran.

Current § 52.220(e) specifies that the time to transport a participant to or from the home must not be more than 60 minutes except under unusual conditions, *e.g.*, bad weather. We propose to delete this provision. Instead, we propose to require that State homes ensure that the care needs of each participant are addressed during travel. This requirement more directly addresses the particular needs of each participant.

Other Technical Changes

We would make other technical, non-substantive changes to provisions amended by or established by this rulemaking. Notably, we describe veterans as being "admitted" (or a derivative) when discussing the adult day health care program, where the current part 52 often uses the term "enrolled" (or a derivative). This is intended to make sure that a reader does not mistake the use of the term "enrolled" to mean enrollment in the VA health care system when it is intended to refer to participation in a State home program of care.

Effect of Rulemaking

The Code of Federal Regulations, as proposed to be revised by this proposed rulemaking, would represent the exclusive legal authority on this subject. No contrary rules or procedures would be authorized. All VA guidance would be read to conform with this proposed rulemaking if possible or, if not possible, such guidance would be superseded by this rulemaking.

Paperwork Reduction Act

This proposed rule includes provisions constituting collections of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521) that require approval by the Office of Management and Budget (OMB). Accordingly, under 44 U.S.C. 3507(d), VA has submitted a copy of this rulemaking to OMB for review.

OMB assigns control numbers to collections of information it approves. VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Proposed § 17.74(q) contains a collection of information under the Paperwork Reduction Act (44 U.S.C. 3501–3521). Proposed §§ 51.20, 51.30, 51.31, 51.42, 51.210, 51.300, 51.310, 51.320, 51.350, and 51.390 contain new collections of information under the Paperwork Reduction Act of 1995. State home domiciliaries are already submitting this information voluntarily as part of their participation in VA's State home program, because this is necessary in order for VA to provide payment to them for the care that they provide. There is, therefore, little or no additional burden to State home domiciliary programs due to this rulemaking. Because these requirements are virtually identical to those imposed upon the other two programs of care and approved under control number 2900–0160, VA seeks to amend that approved collection of information to include State home domiciliaries, as described in further detail below. Additionally, VA proposes minor modifications to collections of information from State home nursing homes and adult day health care programs that are already approved under control number 2900–0160 and set forth at §§ 51.210, 51.415, 51.425, 51.430, and 51.460 of the proposed regulations.

If OMB does not approve the collections of information as requested, VA will immediately remove the provisions containing a collection of information or take such other action as is directed by OMB.

Comments on the collections of information contained in this proposed rule should be submitted to the Office of Management and Budget, Attention: Desk Officer for the Department of Veterans Affairs, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies sent by mail or hand delivery to the Director, Regulation Policy and Management (02REG), Department of Veterans Affairs, 810 Vermont Avenue NW., Room 1068, Washington, DC 20420; fax to (202) 273-9026; or through www.Regulations.gov. Comments should indicate that they are submitted in response to “RIN 2900-AO88 Per Diem Paid to States for Care of Eligible Veterans in State Homes.”

OMB is required to make a decision concerning the collections of information contained in this proposed rule between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication. This does not affect the deadline for the public to comment on the proposed rule.

VA considers comments by the public on proposed collections of information in—

- Evaluating whether the proposed collections of information are necessary for the proper performance of the functions of VA, including whether the information will have practical utility;
- Evaluating the accuracy of VA’s estimate of the burden of the proposed collections of information, including the validity of the methodology and assumptions used;
- Enhancing the quality, usefulness, and clarity of the information to be collected; and
- Minimizing the burden of the collections of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.*, permitting electronic submission of responses.

The proposed amendments to title 38 CFR part 51 contain collections of information under the Paperwork Reduction Act of 1995 for which we are requesting approval by OMB. These collections of information are described immediately following this paragraph, under their respective titles.

Title: Per Diem Paid to States for Care of Eligible Veterans in State Homes.

- *Summary of collection of information:* Section 51.210 would require State homes to submit information about the individuals

responsible for administration of the homes. Most of the collections in § 51.210 are currently approved for State home nursing homes and adult day health care programs of care, with the exception of a new collection in proposed § 51.210(b)(3), which would require State homes to submit the name of the director of nursing services. All of the collections in proposed § 51.210 would constitute new collections for State home domiciliaries.

Sections 51.20, 51.30, 51.31, 51.42, 51.300, 51.310, 51.320, 51.350, and 51.390 would require State homes domiciliary programs to submit information about veterans receiving domiciliary care. State home domiciliaries would be required to furnish an application for recognition based on certification; appeal information, application and justification for payment; records and reports which program management must maintain regarding activities of residents or participants; information relating to whether the domiciliary meets standards concerning residents’ rights and responsibilities prior to admission or enrollment, during admission or enrollment, and upon discharge; the records and reports which management and health care professionals must maintain regarding residents or participants and employees; documents pertain to the management of the home; food menu planning; pharmaceutical records; and life safety documentation. Without access to such information, VA would not be able to determine whether high quality care is being provided to veterans.

The information that VA would collect from State home domiciliaries under this proposed rulemaking is already collected from State home nursing homes and adult day health care programs under OMB control number 2900-0160, pursuant to 38 CFR parts 51 and 52, State Home Programs, and on VA forms as follows: State Home Inspection—Staffing Profile, VA Form 10-3567, Instructions for State Home Report and Statement of Federal Aid Claimed, VA Form 10-5588, State Home Program Application for Veteran Care—Medical Certification, VA Form 10-10SH, Department of Veterans Affairs Certification Regarding Drug-Free Workplace Requirements for Grantees Other Than Individuals, VA Form 10-0143, Statement of Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973, VA Form 10-0143a, Certification Regarding Lobbying, VA Form 10-0144; Statement of Assurance of Compliance with Equal Opportunity Laws, VA Form 10-0144a, and Request for Prescription Drugs from

an Eligible Veteran in a State Home, VA Form 10-0460. VA is amending these forms in a separate request; that request includes a request to include State home domiciliaries as respondents to the forms, in addition to other amendments that would apply as to all State Home programs of care. VA therefore seeks approval in this proposed rule only for the information that would be required of State home domiciliaries by proposed part 51 that would not be included on the forms listed above.

VA proposes to modify the collections of information from State home adult day health care programs of care as set forth at proposed §§ 51.415, 51.425, and 51.430. OMB has approved most of the collections in these sections under OMB control number 2900-0160. VA proposes to modify these collections as follows. In proposed § 51.425(a), VA would require programs to collect documentation of participants’ tuberculosis screening, in addition to the current requirement that State homes record the participant’s medical history and document a physical examination. In proposed § 51.425(b), VA would change the criteria that programs would use to record each participants’ assessment from the Minimum Data Set for Home Care to new criteria developed by VA. In proposed § 51.430(a), VA would clarify that State homes must report sentinel events only when they occur while the veteran is under the care of the home; the current regulations indicate such reports are necessary regardless of when or where a sentinel event occurs.

- *Description of the need for information and proposed use of information:* VA uses this information in order to effectively manage the operations and payment of per diem through the State home domiciliary program of care. Specifically, the information collected is used to determine eligibility of veterans for participation in the program; whether State home domiciliary programs meet appropriate clinical, safety, and quality standards; and to calculate the amount of payments that are due for care provided to veterans on a monthly basis.

- *Description of likely respondents:* State home domiciliary programs that seek payment from VA.

- *Estimated number of respondents:* 53 per year.

- *Estimated frequency of responses:* Once per year.

- *Estimated average burden per response:* 7 minutes.

- *Estimated total annual reporting and recordkeeping burden:* 6.2 hours.

State Home Nursing Homes and Adult Day Health Care Programs

Although this action contains provisions constituting collections of information at 38 CFR 51.20, 51.30, 51.31, 51.42, 51.210, 51.300, 51.310, 51.320, 51.350, 51.390, 51.400, 51.405, 51.410, 51.415, 51.420, 51.425, 51.430, 51.445, 51.460, and 51.475, under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521), no new or proposed revised collections of information are associated with these sections. The proposed regulations impose certain paperwork requirements on States with State homes receiving per diem for nursing home care (at §§ 51.20, 51.30, 51.31, 51.42, and 51.210) and impose similar paperwork requirements on State homes receiving per diem for adult day health care (at §§ 51.20, 51.30, 51.31, 51.210, 51.400, 51.405, 51.410, 51.415, 51.420, 51.425, 51.430, 51.460, and 51.475). The information collection requirements for §§ 51.20, 51.30, 51.31, 51.42, 51.210, 51.400, 51.405, 51.410, 51.415, 51.420, 51.425, 51.430, 51.460, and 51.475 are currently approved by OMB (except for the proposed minor modifications to §§ 51.415, 51.425, and 51.430 described above) and have been assigned OMB control number 2900–0160. This rulemaking simply reorganizes the material to which this control number has already been applied in the current U.S. Code of Federal Regulations. As stated above, VA is revising the forms used for these approved collections from State Home nursing home and adult day health care programs under OMB control number 2900–0160, and will seek approval for the proposed revisions in a separate request for OMB review. Additionally, § 51.42 in effect imposes paperwork requirements on certain Veterans seeking admission to a State home program of care. The information collection requirement pertaining to Veterans under these sections is currently approved by OMB and has been assigned OMB control number 2900–0091.

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed rule would not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. This proposed rule would affect veterans, State homes, and pharmacies. The State homes that are subject to this rulemaking are State government entities under the control of State governments. All State homes are owned, operated and managed by State

governments except for a small number that are operated by entities under contract with State governments. These contractors are not small entities. Also, this rulemaking would not have a consequential effect on any pharmacies that could be considered small entities. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a “significant regulatory action” requiring review by the Office of Management and Budget (OMB), unless OMB waives such review, as “any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of \$100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in this Executive Order.”

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined, and it has been determined to be a significant regulatory action under Executive Order 12866. VA’s impact analysis can be found as a supporting document at <http://www.regulations.gov>, usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its impact analysis are available on VA’s Web site at <http://www.va.gov/orpm/>, by following the

link for “VA Regulations Published From FY 2004 Through Fiscal Year to Date.”

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in an expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100 million or more (adjusted annually for inflation) in any one year. This proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.005, Grants to States for Construction of State Home Facilities; 64.007, Blind Rehabilitation Centers; 64.008, Veterans Domiciliary Care; 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; 64.014, Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.016, Veterans State Hospital Care; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; 64.022, Veterans Home Based Primary Care; and 64.026, Veterans State Adult Day Health Care.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Jose D. Riojas, Chief of Staff, approved this document on January 15, 2015, for publication.

List of Subjects in 38 CFR Parts 17, 51 and 52

Administrative practice and procedure, Claims, Day care, Dental health, Government contracts, Grant programs—health, Grant programs—veterans, Health care, Health facilities, Health professions, Health records, Mental health programs, Nursing homes, Reporting and recordkeeping requirements, Travel and transportation expenses, Veterans.

Approved: June 2, 2015.

William F. Russo,

Acting Director, Office of Regulation Policy & Management.

For the reasons stated in the preamble and under the authority of of 38 U.S.C. 1741–1743 and 38 U.S.C. 1745, the Department of Veterans Affairs proposes to amend 38 CFR parts 17, 51, and 52 as set forth below:

PART 17—MEDICAL

■ 1. The authority citation for part 17 continues to read as follows:

Authority: 38 U.S.C. 501, and as noted in specific sections.

§§ 17.190–17.200 [Removed].

■ 2. Amend part 17 by removing §§ 17.190–17.200.

PART 51—PER DIEM FOR NURSING HOME, DOMICILIARY, OR ADULT DAY HEALTH CARE OF VETERANS IN STATE HOMES

■ 3. The authority citation for part 51 is amended to read as follows:

Authority: 38 U.S.C. 101, 501, 1710, 1720, 1741–1743, 1745, and as stated in specific sections.

■ 4. Subparts A, B, and C of part 51 are revised to read as follows:

Subpart A—General

Sec.

51.1 Purpose and Scope of part 51

51.2 Definitions

Subpart B—Obtaining Recognition and Certification for Per Diem Payments

51.20 Recognition of a State home

51.30 Certification

51.31 Surveys for recognition and/or certification

51.32 Terminating recognition

Subpart C—Eligibility, Rates, and Payments

51.40 Basic per diem rates

51.42 Payment procedures

51.43 Drugs and medicines for certain veterans

51.50 Eligible veterans-nursing home care

51.51 Eligible veterans-domiciliary care

51.58 Standards applicable for payment of per diem

51.59 Authority to continue payment of per diem when veterans are relocated due to emergency

Subpart A—General

§ 51.1 Purpose and scope of part 51.

The purpose of this part is to establish VA's policies, procedures, and standards applicable to the payment of per diem to State homes that provide nursing home care, domiciliary care, or adult day health care to eligible veterans. Subpart B of this part sets forth the procedures for recognition and

certification of a State home. Subpart C sets forth rules governing the rates of, and procedures applicable to, the payment of per diem; the provision of drugs and medicines; and which veterans on whose behalf VA will pay per diem. Subparts D, E, and F set forth standards that must be met by any State home seeking per diem payments for nursing home care (subpart D), domiciliary care (subpart E), or adult day health care (subpart F).

(Authority: 38 U.S.C. 501)

§ 51.2 Definitions.

For the purposes of this part:

Activities of daily living (ADLs) means the functions or tasks for self-care usually performed in the normal course of a day, *i.e.*, mobility, bathing, dressing, grooming, toileting, transferring, and eating.

Adult day health care means a therapeutic outpatient care program that includes one or more of the following services, based on patient care needs: medical services, rehabilitation, therapeutic activities, socialization, and nutrition. Services are provided in a congregate setting.

Clinical nurse specialist means a licensed professional nurse with a master's degree in nursing and a major in a clinical nursing specialty from an academic program accredited by the National League for Nursing.

Director means the Director of the VA medical center of jurisdiction, unless the reference is specifically to another type of director.

Domiciliary care means the furnishing of a home to a veteran, including the furnishing of shelter, food, and other comforts of home, and necessary medical services as defined in this regulation.

Eligible veteran means a veteran whose care in a State home may serve as a basis for per diem payments to the State. The requirements that an eligible veteran must meet are set forth in §§ 51.50 (nursing home care), 51.51 (domiciliary care), and 51.52 (adult day health care).

Licensed medical practitioner means a nurse practitioner, physician, physician assistant, and primary physician or primary care physician.

Nurse practitioner means a licensed professional nurse who is currently licensed to practice in a State; who meets that State's requirements governing the qualifications of nurse practitioners; and who is currently certified as an adult, family, or gerontological nurse practitioner by a nationally recognized body that provides such certification for nurse practitioners, such as the American

Nurses Credentialing Center or the American Academy of Nurse Practitioners.

Nursing home care means the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who require nursing care and related medical services, if such nursing care and medical services are prescribed by, or are performed under the general direction of, persons duly licensed to provide such care. Such term includes services furnished in skilled nursing care facilities, in intermediate care facilities, and in combined facilities. It does not include domiciliary care.

Participant means an individual receiving adult day health care.

Physician means a doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the State.

Physician assistant means a person who meets the applicable State requirements for physician assistant, is currently certified by the National Commission on Certification of Physician Assistants as a physician assistant, and has an individualized written scope of practice that determines the authorization to write medical orders, prescribe medications and to accomplish other clinical tasks under appropriate physician supervision.

Primary physician or Primary care physician means a designated generalist physician responsible for providing, directing and coordinating health care that is indicated for the residents or participants.

Program of care means any or all of the three levels of care for which VA may pay per diem under this part.

Resident means an individual receiving nursing home or domiciliary care.

State means each of the several states, the District of Columbia, the Virgin Islands, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa.

State home means a home recognized and, to the extent required by this part, certified pursuant to this part that a State established primarily for veterans disabled by age, disease, or otherwise, who by reason of such disability are incapable of earning a living. A State home must provide at least one program of care (*i.e.*, domiciliary care, nursing home care, or adult day health care).

VA means the U.S. Department of Veterans Affairs.

Veteran means a veteran under 38 U.S.C. 101.

(Authority: 38 U.S.C. 101, 501, 1741–1743)

Subpart B—Obtaining Recognition and Certification for Per Diem Payments

§ 51.20 Recognition of a State home.

(a) *How to apply for recognition.* To apply for initial recognition of a home for purposes of receiving per diem from VA, a State must submit a letter requesting recognition to the Office of Geriatrics and Extended Care in VA Central Office, 810 Vermont Avenue NW., Washington, DC 20420. The letter must be signed by the State official authorized to make the request. The letter will be reviewed by VA, in accordance with this section.

(b) *Survey and recommendation by Director.* (1) After receipt of a letter requesting recognition, VA will survey the home in accordance with § 51.31 to determine whether the facility and program of care meet the standards in subpart D, E, or F, as applicable. For purposes of the recognition process including the survey, references to State homes in the standards apply to homes that are being considered by VA for recognition as State homes.

(2) If the Director of the VA Medical Center of jurisdiction determines that the applicable standards are met, the Director will submit a written recommendation for recognition to the Under Secretary for Health.

(3) If the Director does not recommend recognition, the Director will submit a written recommendation against recognition to the Under Secretary for Health and will notify in writing the State official who signed the letter submitted under paragraph (a) of this section and the State official authorized to oversee operations of the home. The notification will state the following:

(i) The specific standard(s) not met; and

(ii) The State's right to submit a response, including any additional evidence, within 30 days after the date of the notification to the State.

(c) *Decision by the Under Secretary for Health.* After receipt of a recommendation from the Director, the Under Secretary for Health will award or deny recognition based on all available evidence. The applicant will be notified of the decision. Adverse decisions may be appealed to the Board of Veterans' Appeals (see 38 CFR part 20).

(d) *Effect of recognition.*

(1) Recognition of a State home means that, at the time of recognition, the facility and its program of care meet the applicable requirements of this part. The State home must obtain certification after recognition in accordance with § 51.30.

(2) After a State home is recognized, any new annex, new branch, or other expansion in the size of a home or any relocation of the home to a new facility must be separately recognized. However, changes in the use of particular beds between recognized programs of care and increases in the number of beds that are not described in the previous sentence require certification of the beds, but not recognition, in accordance with paragraph (c)(1) of this section.

(Authority: 38 U.S.C. 501, 511, 1742, 1743, 7104, 7105)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–XXXX.)

§ 51.30 Certification.

(a) *General certification requirement.* In order to be certified, the State home must allow VA to survey the home in accordance with § 51.31. A State home must be certified within 450 days after the State home is recognized. Certifications expire 600 days after the date of their issuance.

(b) *Periodic certifications required.* The Director of the VA medical center of jurisdiction will certify a State home based on a survey conducted at least once every 270–450 days, at VA's discretion, and will notify the State official authorized to oversee operations of the State home of the decision regarding certification within 20 days after the Director's decision.

(c) *Certification of beds based on changes in the program of care—(1) Switching beds between programs of care or increasing beds in a program of care.* When a State home that is recognized to provide both domiciliary and nursing home care changes the care provided in one or more beds, or when a State home increases the number of nursing home or domiciliary beds (except increases described in the first sentence of § 51.20(d)(2) of this part), VA must survey the home taking the proposed changes into account and the Director must certify the beds before VA may pay per diem under this part for care provided in those beds. However, the Director may precertify, at the request of a State home, the increased number of beds or beds that are switched between programs of care. Precertification is authorized if the Director reasonably expects, based on prior surveys and any other relevant information, that the State home will continue to comply with this part until such time as the State home is surveyed and certified. Precertifications will continue for 360 days or until the

Director next issues a certification of the State home under § 51.30(b), whichever occurs first. VA will pay per diem for the care of eligible veterans in the beds provided on and after the date the Director precertifies the beds.

(2) *Decreasing beds for a program of care.* The State must report any decreases in the number of beds that may be used for a particular program of care to the Director within 30 days after such decrease, and must provide an explanation for the decrease.

(d) *Provisional certification—(1) When issuance is required.* After a VA survey, the Director must issue a provisional certification for the surveyed State home if the Director determines that all of the following are true:

(i) The State home does not meet one or more of the applicable standards in this part;

(ii) None of these deficiencies jeopardize the health or safety of any resident or participant;

(iii) No later than 20 days after receipt by the State home of the survey report, the State submitted to the Director a written plan to remedy each deficiency in a specified amount of time; and

(iv) The plan is reasonable and the Director has sent a written notice to the appropriate person(s) at the State home informing them that the Director agrees to the plan.

(2) *Surveys to continue while under provisional certification.* VA will continue to survey the State home while it is under a provisional certification in accordance with this section and § 51.31. After such a survey, the Director will continue the provisional certification if the Director determines that the four criteria listed in paragraphs (c)(1)(i)–(iv) of this section are true.

(3) *Issuance of additional provisional certification.* If the State fails to remedy the identified deficiencies within the amount of time specified in the written plan described in paragraph (d)(1)(iii) of this section, the State must submit, no later than 20 days after the expiration of the time specified in the written plan, a new written plan to remedy each remaining deficiency in a reasonable time. Upon receiving the plan within the 20 day period, the Director may issue another provisional certification if all the criteria listed in paragraphs (c)(1)(i)–(iv) of this section are true. If not, the Director will deny certification.

(e) *Notice and the right to appeal a denial of certification.* A State home has the right to appeal when the Director determines that a State home does not meet the requirements of this part (*i.e.*, denies certification). An appeal is not provided to a State for a State home that

receives a provisional certification because, by providing the corrective action plan necessary to receive a provisional certification, a State demonstrates its acceptance of VA's determination that it does not meet the VA standards for which the corrective action plan was submitted.

(1) *Notice of decision denying certification.* The Director will issue in writing a decision denying certification that sets forth the specific standard(s) not met. The Director will send a copy of this decision to the State official authorized to oversee operations of the State home, and notify that official of the State's right to submit a written appeal to the Under Secretary for Health as stated in paragraph (d)(2). If the State home does not submit a timely written appeal, the Director's decision becomes final and VA will not pay per diem for any care provided on or after the 31st day after the State's receipt of the Director's decision.

(2) *Appeal of denial of certification.* The State must submit a written appeal no later than 30 days after the date of the notice of the denial of certification. The appeal must explain why the denial of certification is inaccurate or incomplete and provide any relevant information not considered by the Director. Any appeal that does not identify a reason for disagreement will be returned to the sender without further consideration. If the State home submits a timely written appeal, the Director's decision will not take effect and VA will continue to pay per diem to the State home pending a decision by the Under Secretary for Health.

(3) *Decision on appeal of a denial of certification.* The Under Secretary for Health will review the matter, including any relevant supporting documentation, and issue a written decision that affirms or reverses the Director's decision. The State will be notified of the decision, which may be appealed to the Board of Veterans' Appeals (see 38 CFR part 20) if it results in a loss of per diem payments to the State. VA will terminate recognition and certification and discontinue per diem payments for care provided on and after the date of the Under Secretary for Health's decision affirming a denial of certification or on a later date that must be specified by the Under Secretary for Health.

(f) *Other appeals.* Appeals of matters not addressed in this section will be governed by 38 CFR part 20.

(Authority: 38 U.S.C. 501, 511, 1741–1743, 7104, 7105).

(The Office of Management and Budget has approved the information collection

requirements in this section under control number 2900–XXXX)

§ 51.31 Surveys for recognition and/or certification.

(a) *General.* Both before and after a home is recognized and certified, VA may survey the home as necessary to determine whether it complies with applicable regulations. VA will provide advance notice before a recognition survey, but advance notice is not required before other surveys. A survey, as necessary, may cover all parts of the home or only certain parts, and may include review, audit, and production of any records that have a bearing on compliance with the requirements of this part (including any reports from state or local entities), as well as the completion and submission to VA of all required forms. The Director will designate the VA officials and/or contractors to survey the home.

(b) *Recognition surveys.* VA will not conduct a recognition survey unless the following minimum requirements are met:

(1) For nursing homes and domiciliaries, the home has at least 21 residents or has a number of residents consisting of at least 50 percent of the resident capacity of the home;

(2) For adult day health care programs of care, the program has at least 10 participants or has a number of participants consisting of at least 50 percent of participant capacity of the program.

(c) *Threats to public, resident, or participant safety.* If VA identifies a condition at the home that poses an immediate threat to public, resident or participant safety, or other information indicating the existence of such a threat, the Director of the VA medical center of jurisdiction will immediately report this to the VA Network Director (10N1–22); the Assistant Deputy Under Secretary for Health (10N); the Office of Geriatrics and Extended Care in VA Central Office; and the State official authorized to oversee operations of the home.

(Authority: 38 U.S.C. 501, 1741, 1742)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–XXXX)

§ 51.32 Terminating recognition.

Once a home has achieved recognition, the recognition will be terminated only if the State requests that the recognition be terminated or VA makes a final decision that affirms the Director's decision not to certify the State home.

(Authority: 38 U.S.C. 501, 1742)

Subpart C—Eligibility, Rates, and Payments

§ 51.40 Basic per diem rates.

(a) *Basic rate.* Except as provided in § 51.41, VA will pay per diem for care provided to an eligible veteran at a State home at the lesser of the following rates:

(1) One-half of the daily cost of the care for each day the veteran is in the State home, as calculated under paragraph (b) of this section.

(2) The basic per diem rate for each day the veteran is in the State home. The basic per diem rate is established by VA for each fiscal year in accordance with 38 U.S.C. 1741(a) and (c).

Note: To determine the number of days that a veteran was in a State home, see paragraph (c) of this section.

(b) *How to calculate the daily cost of a veteran's care.* The daily cost of care consists of those direct and indirect costs attributable to care at the State home, divided by the total number of residents serviced by the program of care. Relevant cost principles are set forth in the Office of Management and Budget (OMB) Circular number A–87, dated May 10, 2004, "Cost Principles for State, Local, and Indian Tribal Governments." (OMB Circulars are available at the addresses in 5 CFR 1310.3.)

(c) *Determining whether a veteran spent a day receiving nursing home and domiciliary care.* Per diem will be paid for each day that the veteran is receiving nursing home or domiciliary care and has an overnight stay. Per diem also will be paid for a day when there is no overnight stay if the State home has an occupancy rate of 90 percent or greater on that day. However, these payments will be made only for the first 10 consecutive days during which the veteran is admitted as a patient for any stay in a VA or other hospital (a hospital stay could occur more than once in a calendar year) and only for the first 12 days in a calendar year during which the veteran is absent for purposes other than receiving hospital care. Occupancy rate is calculated by dividing the total number of residents (including nonveterans) in the nursing home or domiciliary on that day by the total recognized nursing home or domiciliary beds in that State home.

(d) *Determining whether a Veteran spent a day receiving adult day health care.* Per diem will be paid only for a day of adult day health care. For purposes of this section a day of adult day health care means:

(1) Six hours or more in one calendar day in which a veteran receives adult day health care; or

(2) Any two periods of at least 3 hours each but less than 6 hours each in any 2 calendar days in the same calendar month in which the veteran receives adult day health care.

(3) Time during which the State home provides transportation between the veteran's residence and the State home or to a health care visit, or provides staff to accompany a veteran during transportation or a health care visit, will be included as time the veteran receives adult day health care.

(Authority: 38 U.S.C. 501, 1710, 1741–1744)

§ 51.42 Payment procedures.

(a) *Forms required*—(1) *Forms required at time of admission or enrollment.* As a condition for receiving payment of per diem under this part, the State home must submit the forms identified in paragraphs (i) through (ii) of this paragraph to the VA medical center of jurisdiction for each veteran at the time of the veteran's admission or enrollment (or, if the home is not a recognized State home, the home must, after recognition, submit forms for Veterans who received care on and after the date of the completion of the VA survey that provided the basis for determining that the home met the standards of this part), and with any request for a change in the type of per diem paid on behalf of a veteran as a result of a change in the veteran's program of care or a change in the veteran's service-connected disability rating that makes the veteran's care eligible for payment under § 51.41. Copies of VA Forms can be obtained from any VA Medical Center and are available on our Web site at www.va.gov/vaforms. The required forms are:

(i) A completed VA Form 10–10EZ, Application for Medical Benefits (or VA Form 10–10EZR, Health Benefits Renewal Form, if a completed Form 10–10EZ is already on file at VA). *Note:* Domiciliary applicants and residents must complete the financial disclosure sections of VA Forms 1010–EZ and 10–10EZR, and adult day health care applicants may be required to complete the financial disclosure sections of these forms in order to enroll with VA; however, State homes should not require nursing home applicants or residents or adult day health care participants to complete the financial disclosure sections of VA Forms 10–10EZ and 10–10EZR as long as these veterans sign the form, thereby indicating knowledge of, and willingness to pay, any applicable co-pays for the treatment of nonservice-connected conditions by VA.

(ii) A completed VA Form 10–10SH, State Home Program Application for Care—Medical Certification.

(2) *Form required for monthly payments.* Except as provided in (b)(1) and (b)(2), VA pays per diem on a monthly basis for care provided during the prior month. To receive payment, the State must submit each month to the VA a completed, VA Form 10–5588, State Home Report and Statement of Federal Aid Claimed.

(b) *Commencement of payments*—(1) *Per diem payments for a newly-recognized State home.* No per diem payments will be made until VA recognizes the home and each veteran resident for whom VA pays per diem is verified as being eligible; however, per diem payments will be made retroactively for care that was provided on and after the date of the completion of the VA survey that provided the basis for determining that the home met the standards of this part.

(2) *Per diem payments for beds certified or precertified under § 51.30(c).* Per diem will be paid for the care of veterans in beds precertified in accordance with § 51.30(c) retroactive to the date of precertification. Per diem will be paid for the care of veterans in beds certified in accordance with § 51.30(c) retroactive to the date of the completion of the survey if the Director certifies the beds as a result of that survey.

(3) *Payments for eligible veterans.* When a State home admits or enrolls an eligible veteran, VA will pay per diem under this part from the date of receipt of the completed forms required by this section, except that VA will pay per diem from the day on which the veteran was admitted or enrolled if the Director receives the completed forms within 12 days of the date of admission or enrollment. VA will make retroactive payments of per diem under paragraphs (b)(1) and (b)(2) only if the Director receives the completed forms that must be submitted under this section.

(Authority: 38 U.S.C. 510, 1741, 1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–XXXX.)

§ 51.43 Drugs and medicines for certain veterans.

(a) In addition to the per diem payments under § 51.40 of this part, the Secretary will furnish drugs and medicines to a State home as may be ordered by prescription of a duly licensed physician as specific therapy in the treatment of illness or injury for a

veteran receiving nursing home care in a State home, if:

(1) The veteran:
(i) Has a singular or combined rating of less than 50 percent based on one or more service-connected disabilities and is in need of such drugs and medicines for a service-connected disability; and
(ii) Is in need of nursing home care for reasons that do not include care for a VA adjudicated service-connected disability, or

(2) The veteran:
(i) Has a singular or combined rating of 50 or 60 percent based on one or more service-connected disabilities and is in need of such drugs and medicines; and
(ii) Is in need of nursing home care for reasons that do not include care for a VA adjudicated service-connected disability.

(b) VA will also furnish drugs and medicines to a State home for a veteran receiving nursing home, domiciliary and adult day health care in a State home pursuant to 38 U.S.C. 1712(d), as implemented by § 17.96 of this chapter, subject to the limitation in § 51.41(c)(2).

(c) VA may furnish a drug or medicine under paragraph (a) of this section and under § 17.96 of this chapter only if the drug or medicine is included on VA's National Formulary, unless VA determines a non-Formulary drug or medicine is medically necessary.

(d) VA may furnish a drug or medicine under this section and § 17.96 of this chapter by having the drug or medicine delivered to the State home in which the veteran resides by mail or other means and packaged in a form that is mutually acceptable to the State home and VA set forth in a written agreement.

(e) As a condition for receiving drugs or medicine under this section or under § 17.96 of this chapter, the State must submit to the VA medical center of jurisdiction a completed VA Form 10–0460 for each eligible veteran. The corresponding prescriptions also should be submitted to the VA medical center of jurisdiction.

(Authority: 38 U.S.C. 501, 1712, 1745)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–XXXX.)

§ 51.50 Eligible veterans-nursing home care.

A veteran is an eligible veteran for the purposes of payment of per diem for nursing home care under this part if VA determines that the veteran needs nursing home care; is not barred from receiving care based on his or her service (see 38 U.S.C. 5303–5303A), is

not barred from receiving VA pension, compensation or dependency and indemnity compensation based on the character of a discharge from military service (see 38 CFR 3.12) and is within one of the following categories:

- (a) Veterans with service-connected disabilities;
- (b) Veterans who are former prisoners of war, who were awarded the Purple Heart, or who were awarded the medal of honor under 10 U.S.C. 3741, 6241, or 8741 or 14 U.S.C. 491;
- (c) Veterans who were discharged or released from active military service for a disability incurred or aggravated in the line of duty;
- (d) Veterans who receive disability compensation under 38 U.S.C. 1151;
- (e) Veterans whose entitlement to disability compensation is suspended because of the receipt of retired pay;
- (f) Veterans whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. 1151, but only to the extent that such veterans' continuing eligibility for nursing home care is provided for in the judgment or settlement described in 38 U.S.C. 1151;
- (g) Veterans who VA determines are unable to defray the expenses of necessary care as specified under 38 U.S.C. 1722(a);
- (h) Veterans solely seeking care for a disorder associated with exposure to a toxic substance or radiation, for a disorder associated with service in the Southwest Asia theater of operations during the Persian Gulf War, as provided in 38 U.S.C. 1710(e), or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as provided and limited in 38 U.S.C. 1710(e);
- (i) Veterans who agree to pay to the United States the applicable co-payment determined under 38 U.S.C. 1710(f) and 1710(g).

Note: Neither enrollment in the VA healthcare system nor eligibility to enroll is required to be an eligible veteran for the purposes of payment of per diem for nursing home care.

(Authority: 38 U.S.C. 501, 1710, 1741–1743)

§ 51.51 Eligible veterans-domiciliary care.

(a) A veteran is an eligible veteran for the purposes of payment of per diem for domiciliary care in a State home under this part if VA determines that the veteran is not barred from receiving care based on his or her service (see 38 U.S.C. 5303–5303A), is not barred from receiving VA pension, compensation or dependency and indemnity compensation based on the character of a discharge from military service (see 38 CFR 3.12), and the veteran is:

- (1) A veteran whose annual income does not exceed the maximum annual rate of pension payable to a veteran in need of regular aid and attendance; or
- (2) A veteran who VA determines has no adequate means of support. The phrase no adequate means of support refers to an applicant for domiciliary care whose annual income exceeds the rate of pension described in paragraph (1), but who is able to demonstrate to competent VA medical authority, on the basis of objective evidence, that deficits in health and/or functional status render the applicant incapable of pursuing substantially gainful employment, as determined by the Chief of Staff of the VA medical center of jurisdiction, and who is otherwise without the means to provide adequately for self, or be provided for in the community.

(b) For purposes of this section, the eligible veteran must be able to perform the following:

- (1) Daily ablutions, such as brushing teeth; bathing; combing hair; body eliminations, without assistance.
- (2) Dress self, with a minimum of assistance.
- (3) Proceed to and return from the dining hall without aid.
- (4) Feed self.
- (5) Secure medical attention on an ambulatory basis or by use of personally propelled wheelchair.
- (6) Have voluntary control over body eliminations or control by use of an appropriate prosthesis.
- (7) Share in some measure, however slight, in the maintenance and operation of the State home.
- (8) Make rational and competent decisions as to his or her desire to remain or leave the State home.

(Authority: 38 U.S.C. 101, 501, 1710, 1741–1743)

§ 51.52 Eligible veterans-adult day health care.

A veteran is an eligible veteran for payment of per diem to a State for adult day health care if VA determines that the veteran

- (a) Is not barred from receiving VA pension, compensation or dependency and indemnity compensation based on the character of a discharge from military service (see 38 CFR 3.12)
- (b) Is enrolled in the VA health care system,
- (c) Would otherwise require nursing home care;
- and
- (d) Needs adult day health care because the veteran meets any one of the following conditions:

(1) The veteran has three or more Activities of Daily Living (ADL) dependencies.

(2) The veteran has significant cognitive impairment.

(3) The veteran has two ADL dependencies and two or more of the following conditions:

- (i) Seventy-five years old or older;
 - (ii) High use of medical services, *i.e.*, three or more hospitalizations per calendar year, or twelve or more visits to outpatient clinics and emergency evaluation units per calendar year;
 - (iii) Diagnosis of clinical depression;
- or
- (iv) Living alone in the community.
- (4) The veteran does not meet the criteria in paragraphs (d)(1), (d)(2), or (d)(3) of this section, but nevertheless is determined by a VA licensed medical practitioner to need adult day health care services.

(Authority: 38 U.S.C. 501, 1720(f), 1741–1743)

§ 51.58 Standards applicable for payment of per diem.

A State home must meet the standards in the applicable subpart to be recognized, certified, and receive per diem for that program of care:

- (a) For nursing home care, subpart D.
- (b) For domiciliary care, subpart E.
- (c) For adult day health care, subpart F.

(Authority: 38 U.S.C. 501)

§ 51.59 Authority to continue payment of per diem when veterans are relocated due to emergency.

(a) *Definition of emergency.* For the purposes of this section, emergency means an occasion or instance where all of the following are true:

(1) It would be unsafe for veterans receiving care at a State home to remain in that home.

(2) The State is not, or believes that it will not be, able to provide care in the State home on a temporary or long-term basis for any or all of its veteran residents due to a situation involving the State home, and not due to a situation where a particular veteran's medical condition requires that the veteran be transferred to another facility, such as for a period of hospitalization.

(3) The State determines that the veterans must be evacuated to another facility or facilities.

(b) *General authority to pay per diem during relocation period.*

Notwithstanding any other provision of this part, VA will continue to pay per diem for a period not to exceed 30 days for any eligible veteran who resided in a State home, and for whom VA was paying per diem, if such veteran is evacuated during an emergency into a facility other than a VA nursing home,

hospital, domiciliary, or other VA site of care if the State is responsible for providing or paying for the care. VA will not pay per diem payments under this section for more than 30 days of care provided in the evacuation facility, unless the official who approved the emergency response under paragraph (e) of this section determines that it is not reasonably possible to return the veteran to a State home within the 30-day period, in which case such official will approve additional period(s) of no more than 30 days in accordance with this section. VA will not provide per diem if VA determines that a veteran is or has been placed in a facility that does not meet the standards set forth in paragraph (c)(1) of this section, and VA may recover all per diem payments made for the care of the veteran in that facility.

(c) *Selection of evacuation facilities.* The following standards and procedures apply to the selection of an evacuation facility in order for VA to continue to pay per diem during an emergency; these standards and procedures also apply to evacuation facilities when veterans are evacuated from a nursing home in which care is being provided pursuant to a contract under 38 U.S.C. 1720.

(1) Each veteran who is evacuated must be placed in a facility that, at a minimum, will meet the needs for food, shelter, toileting, and essential medical care of that veteran.

(2) For veterans evacuated from nursing homes, the following types of facilities may meet the standards under paragraph (c)(1) of this section:

- (i) VA Community Living Centers;
- (ii) VA contract nursing homes;
- (iii) Centers for Medicare and Medicaid Services certified facilities; and

(iv) Licensed nursing homes.

Note to paragraph (c)(2): If none of the above options are available, veterans may be evacuated temporarily to other facilities that meet the standards under paragraph (c)(1) of this section.

(3) For veterans evacuated from domiciliaries, the following types of facilities may meet the standards in paragraph (c)(1) of this section:

- (i) Emergency evacuation facilities identified by the city or State;
- (ii) Assisted living facilities; and
- (iii) Hotels.

(d) *Applicability to adult day health care programs of care.* Notwithstanding any other provision of this part, VA will continue to pay per diem for a period not to exceed 30 days for any eligible veteran who was receiving adult day health care, and for whom VA was

paying per diem, if the adult day health care facility becomes temporarily unavailable due to an emergency.

Approval of a temporary program of care for such veteran is subject to paragraph (e) of this section. If after 30 days the veteran cannot return to the adult day health care program in the State home, VA will discontinue per diem payments unless the official who approved the emergency response under paragraph (e) of this section determines that it is not reasonably possible to provide care in the State home or to relocate an eligible veteran to a different recognized or certified facility, in which case such official will approve additional period(s) of no more than 30 days at the temporary program of care in accordance with this section. VA will not provide per diem if VA determines that a veteran was provided adult day health care in a facility that does not meet the standards set forth in paragraph (c)(1) of this section, and VA may recover all per diem payments made for the care of the veteran in that facility.

(e) *Approval of response.* Per diem payments will not be made under this section unless and until the Director of the VA medical center of jurisdiction determines, or the director of the VISN in which the State home is located (if the VAMC Director is not capable of doing so) determines, that an emergency exists and that the evacuation facility meets VA standards set forth in paragraph (c)(1) of this section.

(Authority 38 U.S.C. 501, 1720, 1742)

■ 4. Amend the heading of Subpart D, part 51, to read as follows:

Subpart D—Standards applicable to the payment of per diem for nursing home care.

§ 51.120 [Amended]

■ 5. Amend § 51.120(a)(3) by replacing “Chief Consultant, Office of Geriatrics and Extended Care (114)” with “Office of Geriatrics and Extended Care in VA Central Office.”

§ 51.140 [Amended]

■ 6. Amend § 51.140(d)(4) by removing “who refuse food served”.

■ 7. Amend § 51.210 by:

■ a. In paragraph (b), replacing “Chief Consultant, Office of Geriatrics and Extended Care (114)” with “Office of Geriatrics and Extended Care”.

■ b. Revising paragraph (b)(2), redesignating (b)(3) as (b)(4), and adding new paragraphs (b)(3) and (h)(3), to read as follows:

§ 51.210 Administration.

* * * * *

(b) * * *

(2) The State home administrator;

(3) The director of nursing services (or other individual in charge of nursing services); and

(4) The State employee responsible for oversight of the State home if a contractor operates the State home.

* * * * *

(h)(3) If a veteran requires health care that the State home is not required to provide under this part, the State home may assist the veteran in obtaining that care from sources outside the State home, including the Veterans Health Administration. If VA is contacted about providing such care, VA will determine the best option for obtaining the needed services and will notify the veteran or the authorized representative of the veteran.

* * * * *

■ 8. Amend part 51 by adding subparts E and F, to read as follows:

Subpart E—Standards Applicable to the Payment of Per Diem for Domiciliary Care

Sec

- 51.300 Resident rights and behavior; State home practices; quality of life
- 51.310 Resident assessment
- 51.320 Quality of care
- 51.330 Nursing care
- 51.340 Physician and other licensed medical practitioner services
- 51.350 Provision of certain specialized services and environmental requirements
- 51.390 Administration

Subpart F—Standards Applicable to Adult Day Health Care Programs of Care

- 51.400 Participant rights
- 51.405 Participant and family caregiver responsibilities
- 51.410 *Transfer and discharge*
- 51.411 Program practices
- 51.415 Restraints, abuse, and staff treatment of participants
- 51.420 Quality of life
- 51.425 Physician orders and participant medical assessment
- 51.430 Quality of care
- 51.435 Nursing services
- 51.440 Dietary services
- 51.445 Physician services
- 51.450 Specialized rehabilitative services
- 51.455 Dentist
- 51.460 Administration of drugs
- 51.465 Infection control
- 51.470 Physical environment
- 51.475 Administration
- 51.480 Transportation

Subpart E—Standards Applicable to the Payment of Per Diem for Domiciliary Care

§ 51.300 Resident rights and behavior; state home practices; quality of life.

The State home must protect and promote the rights and quality of life of each resident receiving domiciliary care, and otherwise comply with the

requirements set forth in §§ 51.70, 51.80, 51.90, and 51.100. For purposes of this section, the references in the cited sections to nursing home and nursing facility refer to a domiciliary.

(Authority: 38 U.S.C. 501, 1741–1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–XXXX.)

§ 51.310 Resident assessment.

The State home must conduct a comprehensive, accurate, and written assessment of each resident's medical and functional capacity upon admission, annually, and as required by a change in the resident's condition.

(a) *Admission orders.* At the time each resident is admitted, the State home must have physician orders for the resident's immediate care and a medical assessment, including a medical history and physical examination, within a time frame appropriate to the resident's condition, not to exceed 72 hours after admission, except when the required physical examination was performed within five days before admission and the findings were recorded in the medical record on admission, in which case the physician orders may be submitted when available.

(b) *Use.* The State home must use the results of the assessment to develop, review, and revise the resident's treatment plan.

(c) *Coordination of assessments.* Each assessment must be conducted or coordinated by a registered nurse with the appropriate participation of health professionals, including at least one physician, the registered nurse, and one social worker. The registered nurse must sign and certify the assessment.

(d) *Treatment plans.* (1) The State home must develop a treatment plan for each resident that includes measurable objectives and timetables to address a resident's physical, mental, and psychosocial needs that are identified in the written assessment. The treatment plan must describe the following:

(i) The services that are to be furnished to support the resident's highest practicable physical, mental, and psychosocial well-being as required under § 51.350; and

(ii) Any services that would otherwise be required under § 51.350 but are not provided due to the resident's exercise of rights under § 51.300, including the right to refuse treatment.

(2) A treatment plan must be:

(i) Developed within 7 calendar days after completion of the comprehensive assessment;

(ii) Prepared by health professionals, that include the primary physician, a social worker, and a registered nurse who have responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident and the resident's family (subject to the consent of the resident) or the resident's legal representative, if appropriate; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

(3) The services provided by the facility must—

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each resident's written treatment plan.

(e) *Discharge summary.* Prior to discharging a resident, the State home must prepare a discharge summary that includes—

(1) A recapitulation of the resident's stay;

(2) A summary of the resident's status at the time of the discharge to include a summary of the resident's progress on the treatment plan in paragraph (d)(2) of this section; and

(3) A post-discharge plan of care that is developed with the participation of the resident and, to the extent practicable and appropriate, his or her family, (subject to the consent of the resident) and legal representative, which will assist the resident to adjust to his or her new living environment.

(Authority: 38 U.S.C. 501, 1720(f), 1741–1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–XXXX.)

§ 51.320 Quality of care.

The State home must provide each resident with the care described in this subpart in accordance with the assessment and plan of care.

(a) *Reporting of sentinel events.* (1) A sentinel event is an adverse event that results in the loss of life or limb or permanent loss of function.

(2) Examples of sentinel events are as follows:

(i) Any resident death, paralysis, coma or other major permanent loss of function associated with a medication error; or

(ii) Any suicide of a resident; or

(iii) Assault, homicide or other crime resulting in resident death or major permanent loss of function; or

(iv) A resident fall that results in death or major permanent loss of

function as a direct result of the injuries sustained in the fall.

(3) The State home must report sentinel events to the Director within 24 hours of identification. The VA medical center of jurisdiction must report sentinel events by notifying the VA Network Director (10N1–10N22) and the Director, Office of Geriatrics and Extended Care—Operations (10NC4) within 24 hours of notification.

(4) The State home must establish a mechanism to review and analyze a sentinel event resulting in a written report to be submitted to the VA Medical Center of jurisdiction no later than 10 working days following the event. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and the State home.

(b) *Activities of daily living.* Based on the comprehensive assessment of a resident, the State home must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable, and the resident is given appropriate treatment and services to maintain or improve his activities of daily living. This includes the resident's ability to:

(1) Bathe, dress, and groom;

(2) Transfer and ambulate;

(3) Toilet;

(4) Eat; and

(5) Talk or otherwise communicate.

(c) *Vision and hearing.* To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the State home must, if necessary, assist the resident:

(1) In making appointments, and

(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

(d) *Mental and Psychosocial functioning.* Based on the comprehensive assessment of a resident, the State home must assist a resident who displays mental or psychosocial adjustment difficulty, obtain appropriate treatment and services to correct the assessed problem.

(e) *Accidents.* The State home must ensure that:

(1) The resident environment remains as free of accident hazards as possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(f) *Nutrition.* The State home must follow § 51.120(j) regarding nutrition in providing domiciliary care.

(g) *Special needs.* The State home must provide residents with the following services, if needed:

- (1) Injections;
- (2) Colostomy, ureterostomy, or ileostomy care;
- (3) Respiratory care;
- (4) Foot care; and
- (5) Non-customized or non-individualized prosthetic devices.

(h) *Unnecessary drugs.* The State home must ensure that the standards set forth in § 51.120(m) regarding unnecessary drugs are followed in providing domiciliary care.

(i) *Medication Errors.* The State home must ensure that the standards set forth in § 51.120(n) regarding medication errors are followed in providing domiciliary care.

(Authority: 38 U.S.C. 101, 501, 1710, 1741–1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–XXXX.)

§ 51.330 Nursing care.

The State home must provide an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing care needs, as determined by the resident assessment and individualized treatment plans, of all residents within the facility, 24 hours a day, 7 days a week.

(a) The nursing service must be under the direction of a full-time registered nurse who is currently licensed by the State and has, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing service's staff.

(b) The director of nursing service must designate a licensed nurse as the supervising nurse for each tour of duty.

(Authority: 38 U.S.C. 101, 501, 1710, 1741–1743)

§ 51.340 Physician and other licensed medical practitioner services.

The State home must provide the necessary primary care for its residents to permit them to attain or maintain the highest practicable physical, mental, and psychosocial well-being. When a resident needs care other than what the State home is required to provide under this subpart, the State home is responsible for assisting the resident in

obtaining that care. The State home must ensure that a physician personally approves in writing a recommendation that an individual be admitted to a domiciliary. Each resident must remain at all times under the care of a licensed medical practitioner assigned by the State home. The name of the practitioner will be listed in the resident's medical record. The State home must ensure that all of the following conditions are met:

(a) *Supervision of medical practitioners.* Any licensed medical practitioner who is not a physician may provide medical care to a resident within the practitioner's scope of practice without physician supervision when permitted by state law.

(b) *Availability of medical practitioners.* If the resident's assigned licensed medical practitioner is unavailable, another licensed medical practitioner must be available to provide care for that resident.

(c) *Visits.* The primary care physician or other licensed medical practitioner, for each visit required by paragraph (d) of this section, must—

- (1) Review the resident's total program of care, including medications and treatments;
- (2) Write, sign, and date progress notes; and
- (3) Sign and date all orders.

(d) *Frequency of visits.* The resident must be seen by the primary care physician or other licensed medical practitioner at least once every 30 days for the first 90 days after admission, and at least once a calendar year thereafter, or more frequently based on the condition of the resident.

(e) *Availability of emergency care.* The State home must assist residents in obtaining emergency care.

(Authority: 38 U.S.C. 101, 501, 1710, 1741–1743)

§ 51.350 Provision of certain specialized services and environmental requirements.

The State home must comply with the requirements, set forth in §§ 51.140, 51.170, 51.180, 51.190, and 51.200 concerning dietary, dental, pharmacy services, infection control, and physical environment. For purposes of this section, the references in the cited sections to nursing home and nursing facility refer to a domiciliary.

(Authority: 38 U.S.C. 101, 501, 1710, 1741–1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–XXXX.)

§ 51.390 Administration.

The State home must follow § 51.210 regarding administration in providing domiciliary care. For purposes of this section, the references in the cited section to nursing home and nursing home care refer to a domiciliary and domiciliary care.

(Authority: 38 U.S.C. 101, 501, 1710, 1741–1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–XXXX.)

Subpart F—Standards Applicable to Adult Day Health Care Programs of Care

§ 51.400 Participant rights.

The State home must protect and promote the rights of a participant in an adult day health care program, including the rights set forth in § 51.70, except for the right set forth in § 51.70(m). For purposes of this section, the references in the cited section to resident refer to a participant.

(Authority: 38 U.S.C. 501)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0160.)

§ 51.405 Participant and family caregiver responsibilities.

The State home must post in a place where participants in the adult day health care program and their families will see it a written statement of participant and family caregiver responsibilities and must provide a copy to the participant and caregiver at or before the time of the intake screening. The statement of responsibilities must include the following responsibilities:

- (a) Treat personnel with respect and courtesy;
- (b) Communicate with staff to develop a relationship of trust;
- (c) Make appropriate choices and seek appropriate care;
- (d) Ask questions and confirm your understanding of instructions;
- (e) Share opinions, concerns, and complaints with the program director;
- (f) Communicate any changes in the participant's condition;
- (g) Communicate to the program director about medications and remedies used by the participant;
- (h) Let the program director know if the participant decides not to follow any instructions or treatment; and
- (i) Communicate with the adult day health care staff if the participant is unable to attend adult day health care.

(Authority: 38 U.S.C. 501)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0160)

§ 51.410 Transfer and discharge.

(a) *Definition.* For purposes of this section, the term “transfer and discharge” includes movement of a participant to a program outside of the adult day health care program whether or not that program of care is in the same facility.

(b) *Transfer and discharge requirements.* The possible reasons for transfer and discharge must be discussed with the participant and, to the extent practicable and appropriate, with family members (subject to the consent of the participant) and legal representatives at the time of intake screening. In the case of a transfer and discharge to a hospital, the transfer and discharge must be to the hospital closest to the adult day health care facility that is capable of providing the necessary care. The State home must permit each participant to remain in the program of care, and not transfer or discharge the participant from the program of care unless:

(1) The transfer and discharge is necessary for the participant’s welfare and the participant’s needs cannot be met in the adult day health care setting;

(2) The transfer and discharge is appropriate because the participant’s health has improved sufficiently so the participant no longer needs the services provided in the adult day health care program;

(3) The safety of individuals in the facility is endangered;

(4) The health of individuals in the facility would otherwise be endangered;

(5) The participant has failed, after reasonable and appropriate notice, to pay for participation in adult day health care; or

(6) The adult day health care program of care ceases to operate.

(c) *Notice before transfer.* Before an adult day health care program undertakes the transfer and discharge of a participant, the State home must:

(1) Notify the participant or the legal representative of the participant and, if appropriate, a family member, of the transfer and discharge and the reasons for the move in writing and in a language and manner they can understand;

(2) Record the reasons in the participant’s clinical record; and

(3) Include in the notice the items described in paragraph (e) of this section.

(d) *Timing of the notice.* (1) The notice of transfer and discharge required under paragraph (c) of this section must be made by the State home at least 30 days before the participant is given a transfer and discharge, except when specified in paragraph (d)(2) of this section.

(2) Notice may be made as soon as practicable before a transfer and discharge when—

(i) The safety of individuals in the facility would be endangered;

(ii) The health of individuals in the facility would be otherwise endangered;

(iii) The participant’s health improves sufficiently so the participant no longer needs the services provided by the adult day health care program of care; or

(iv) The resident’s needs cannot be met in the adult day health care program of care.

(e) *Contents of the notice.* The written notice specified in paragraph (c) of this section must include the following:

(1) The reason for the transfer and discharge;

(2) The effective date of the transfer and discharge;

(3) The location to which the participant is taken in accordance with the transfer and discharge, if any;

(4) A statement that the participant has the right to appeal the action to the State official responsible for the oversight of State Veterans Home programs; and

(5) The name, address and telephone number of the State long-term care ombudsman.

(f) *Orientation for transfer and discharge.* The State home must provide sufficient preparation and orientation to participants to ensure safe and orderly transfer and discharge from the State home.

(g) *Written policy.* The State home must have in effect a written transfer and discharge procedure that reasonably ensures that:

(1) Participants will be given a transfer and discharge from the adult day health care program to the hospital, and ensured of timely admission to the hospital when transfer and discharge is medically appropriate as determined by a physician; and

(2) Medical and other information needed for care and treatment of participants will be exchanged between the facility and the hospital.

(Authority: 38 U.S.C. 501, 1741–1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0160)

§ 51.411 Program practices.

(a) *Equal access to quality care.* The State home must establish and maintain identical policies and practices regarding transfer and discharge under § 51.410 and the provision of services for all participants regardless of the source of payment.

(b) *Admission policy.* The State home must not require a third-party guarantee of payment as a condition of admission or expedited admission, or continued admission in the program of care. However, the State home may require a participant or an individual who has legal access to a participant’s income or resources to pay for the care from the participant’s income or resources, when available.

(c) *Hours of operation.* Each adult day health care program of care must provide at least 8 hours of operation 5 days a week. The hours of operation must be flexible and responsive to caregiver needs.

(Authority: 38 U.S.C. 501, 1741–1743)

§ 51.415 Restraints, abuse, and staff treatment of participants.

The State home must meet the requirements regarding the use of restraints, abuse, and other matters concerning staff treatment of participants set forth in § 51.90. For purposes of this section, the references in the cited section to resident refer to a participant.

(Authority: 38 U.S.C. 501)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–XXXX.)

§ 51.420 Quality of life.

The State home must provide an environment that supports the quality of life of each participant by maximizing the participant’s potential strengths and skills.

(a) *Dignity.* The State home must promote care for participants in a manner and in an environment that maintains or enhances each participant’s dignity and respect in full recognition of his or her individuality.

(b) *Self-determination and participation.* The State home must ensure that the participant has the right to—

(1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;

(2) Interact with members of the community both inside and outside the facility; and

(3) Make choices about aspects of his or her life in the facility that are significant to the participant.

(c) *Participant and family concerns.* The State home must document any concerns submitted to the management of the program by participants or family members.

(1) A participant's family has the right to meet with families of other participants in the program.

(2) Staff or visitors may attend meetings of participant or family groups at the group's invitation.

(3) The State home must respond to written requests that result from group meetings.

(4) The State home must listen to the views of any participant or family group and act upon the concerns of participants and families regarding policy and operational decisions affecting participant care in the program.

(d) *Participation in other activities.* The State home must ensure that a participant has the right to participate in social, religious, and community activities that do not interfere with the rights of other participants in the program.

(e) *Therapeutic participant activities.* (1) The State home must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each participant.

(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who:

(i) Is licensed, if applicable, by the State in which practicing; and

(ii) Is certified as a therapeutic recreation specialist or an activities professional by a recognized certifying body.

(3) A critical role of adult day health care is to build relationships and create a culture that supports, involves, and validates the participant. Therapeutic activity refers to that supportive culture and is a significant aspect of the individualized plan of care. A participant's activity includes everything the individual experiences during the day, not just arranged events. As part of effective therapeutic activity, the adult day health care program of care must:

(i) Provide direction and support for participants, including breaking down activities into small, discrete steps or behaviors, if needed by a participant;

(ii) Have alternative programming available for any participant unable or unwilling to take part in group activity;

(iii) Design activities that promote personal growth and enhance the self-

image and/or improve or maintain the functioning level of participants to the extent possible;

(iv) Provide opportunities for a variety of involvement (social, intellectual, cultural, economic, emotional, physical, and spiritual) at different levels, including community activities and events;

(v) Emphasize participants' strengths and abilities rather than impairments and contribute to participants' feelings of competence and accomplishment; and

(vi) Provide opportunities to voluntarily perform services for community groups and organizations.

(f) *Social services.* (1) The State home must provide medically-related social services to participants and their families.

(2) An adult day health care program of care must provide a qualified social worker to furnish social services.

(3) Qualifications of social worker. A qualified social worker is an individual with:

(i) A bachelor's degree in social work from a school accredited by the Council of Social Work Education (*Note:* A master's degree social worker with experience in long-term care is preferred);

(ii) A social work license from the State in which the State home is located, if that license is offered by the State; and

(iii) A minimum of one year of supervised social work experience in a health care setting working directly with individuals.

(4) The State home must have sufficient social workers and support staff to meet participant and family social services needs. The adult day health care program of care must:

(i) Provide counseling to participants and families/caregivers;

(ii) Facilitate the participant's adaptation to the adult day health care program of care and active involvement in the plan of care, if appropriate;

(iii) Arrange for services not provided by adult day health care and work with these resources to coordinate services;

(iv) Serve as an advocate for participants by asserting and safeguarding the human and civil rights of the participants;

(v) Assess signs of mental illness and/or dementia and make appropriate referrals;

(vi) Provide information and referral for persons not appropriate for adult day health care;

(vii) Provide family conferences and serve as liaison between participant, family/caregiver and program staff;

(viii) Provide individual or group counseling and support to caregivers and participants;

(ix) Conduct support groups or facilitate participant or family/caregiver participation in support groups;

(x) Assist program staff in adapting to changes in participants' behavior; and

(xi) Provide or arrange for individual, group, or family psychotherapy for participants with significant psychosocial needs.

(5) Space for social services must be adequate to ensure privacy for interviews.

(g) *Environment.* The State home must provide:

(1) A safe, clean, comfortable, and homelike environment, and support the participants' ability to function as independently as possible and to engage in program activities;

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

(3) Private storage space that can be secured with a lock for each participant sufficient for a change of clothes;

(4) Interior signs to facilitate participants' ability to move about the facility independently and safely;

(5) A clean bed or reclining chair available for acute illness;

(6) A shower for residents;

(7) Adequate and comfortable lighting levels in all areas;

(8) Comfortable and safe temperature levels; and

(9) Comfortable sound levels.

(Authority: 38 U.S.C. 101, 501, 1741–1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0160.)

§ 51.425 Physician orders and participant medical assessment.

(a) *Admission.* At the time of admission, the State home must have physician orders for the participant's immediate care and a medical assessment including a medical history and physical examination (with documentation of TB screening) completed no earlier than 30 days before admission.

(b) *Assessments.* On the participant's first visit, the State home must ensure that the participant has an individualized care plan that meets the requirements of paragraph (d) of this section. Additional assessments must be conducted annually, as well as promptly after every significant change in the participant's physical, mental, or social condition. The State home must immediately change the participant's

care plan when warranted by an assessment. Assessments must meet the other applicable criteria of this section, and the written assessment must address the following:

- (1) Ability to ambulate,
- (2) Ability to use bathroom facilities,
- (3) Ability to eat and swallow,
- (4) Ability to hear,
- (5) Ability to see,
- (6) Ability to experience feeling and movement,
- (7) Ability to communicate,
- (8) Risk of wandering,
- (9) Risk of elopement,
- (10) Risk of suicide,
- (11) Risk of deficiencies regarding social interactions, and

(12) Special needs (such as regarding medication, diet, nutrition, hydration, prosthetics, etc.).

(c) *Coordination of assessment.* (1) Each assessment must be conducted or coordinated with the appropriate participation of health professionals.

(2) Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(d) *Care plans.* (1) The State home must ensure that each participant has a care plan. A participant's care plan must be individualized and must include measurable objectives and timetables to meet all physical, mental, and psychosocial needs identified in the most recent assessment. The care plan must describe the following:

(i) The services that are to be provided as part of the program of care and by other sources to attain or maintain the participant's highest physical, mental, and psychosocial well-being as required under § 51.430;

(ii) Any services that would otherwise be required under § 51.430 but are not provided due to the participant's exercise of rights under § 51.70, including the right to refuse treatment under § 51.70(b)(4);

(iii) Type and scope of interventions to be provided in order to reach desired, realistic outcomes;

(iv) Roles of participant and family/caregiver; and

(v) Discharge or transition plan, including specific criteria for discharge or transfer.

(2) The services provided or arranged by the State home must:

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each participant's care plan.

(e) *Discharge summary.* Prior to discharging a participant, the State home must prepare a discharge summary that includes:

(1) A recapitulation of the participant's care;

(2) A summary of the participant's status at the time of the discharge to include items in paragraph (b) of this section; and

(3) A discharge/transition plan related to changes in service needs and changes in functional status that prompted another level of care.

(Authority: 38 U.S.C. 501, 1741–1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–XXXX.)

§ 51.430 Quality of care.

Each participant must receive, and the State home must provide, the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) *Reporting of sentinel events.*

(1) *Definition.* A “sentinel event” is defined in § 51.120(a)(1).

(2) *Duty to report, review, and prevent sentinel events.* The State home must comply with the duties to report, review, and prevent sentinel events as set forth in § 51.120(a)(3) and (4) except that the duty to report applies only to a sentinel event that occurs while the participant is under the care of the State home, including while in State home-provided transportation.

(3) *Review and prevention of sentinel events.* The State home must establish a mechanism to review and analyze a sentinel event resulting in a written report to be submitted to the VA Medical Center of jurisdiction no later than 10 working days after the event. The purpose of the review and analysis of a sentinel event is to prevent future injuries to participants, visitors, and personnel.

(b) *Activities of daily living.* Based on the comprehensive assessment of a participant, the State home must ensure that:

(1) *No diminution in activities of daily living.* A participant's abilities in activities of daily living do not diminish unless the circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the participant's ability to—

- (i) Bathe, dress, and groom;
- (ii) Transfer and ambulate;
- (iii) Toilet; and
- (iv) Eat.

(2) *Appropriate treatment and services given.* A participant is given the appropriate treatment and services to maintain or improve his or her abilities

specified in paragraph (b)(1) of this section.

(3) *Necessary services provided to participant unable to carry out activities of daily living.* A participant who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, hydration, grooming, personal and oral hygiene, mobility, and bladder and bowel elimination.

(c) *Mental and Psychosocial functioning.* The State home must make counseling and related psychosocial services available for improving mental and psychosocial functioning of participants with mental or psychosocial needs. The services available must include counseling and psychosocial services provided by licensed independent mental health professionals.

(d) *Medication errors.* The State home must comply with § 51.120(n) with respect to medication errors.

(Authority: 38 U.S.C. 101, 501, 1741–1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–XXXX.)

§ 51.435 Nursing services.

The State home must provide an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing care needs, as determined by participant assessment and individualized comprehensive plans of care, of all participants in the program.

(a) There must be at least one registered nurse on duty each day of operation of the adult day health care program of care. This nurse must be currently licensed by the State and must have, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing and program assistants.

(b) The number and level of nursing staff is determined by the authorized capacity of participants and the nursing care needs of the participants.

(c) Nurse staffing must be adequate for meeting the standards of this part.

(Authority: 38 U.S.C. 501, 1741–1743)

§ 51.440 Dietary services.

The State home must comply with the requirements concerning the dietary services set forth in § 51.140. For purposes of this section, the references in the cited section to resident refer to a participant.

(Authority: 38 U.S.C. 101, 501, 1741–1743)

§ 51.445 Physician services.

As a condition of enrollment in adult day health care program, a participant must have a written physician order for enrollment. If a participant's medical needs require that the participant be placed in an adult day health care program that offers medical supervision, the order for enrollment from the physician must state that. Each participant must remain under the care of a physician.

(a) *Physician supervision.* If the adult day health care program offers medical supervision, the program management must ensure that:

(1) The medical care of each participant is supervised by a primary care physician;

(2) Each participant's medical record must contain the name of the participant's primary physician; and

(3) Another physician is available to supervise the medical care of participants when their primary physician is unavailable.

(b) *Frequency of physician reviews.* If the adult day health care program offers medical supervision:

(1) The participant must be seen by the primary physician at least annually and as indicated by a change of condition.

(2) The program management must have a policy to help ensure that adequate medical services are provided to the participant.

(3) At the option of the primary physician, required reviews in the program after the initial review may alternate between personal physician reviews and reviews by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.

(c) *Availability of acute care.* If the adult day health care program offers medical supervision, the program management must provide or arrange for the provision of acute care when it is indicated.

(d) *Availability of physicians for emergency care.* In case of an emergency, the program management must ensure that participants are able to obtain emergency care when necessary.

(e) *Physician delegation of tasks.* (1) A primary physician may delegate tasks to:

(i) A certified physician assistant or a certified nurse practitioner, or

(ii) A clinical nurse specialist who—
(A) Is acting within the scope of practice as defined by State law; and
(B) Is under the supervision of the physician.

(2) The primary physician may not delegate a task when the provisions of this part specify that the primary

physician must perform it personally, or when the delegation is prohibited under State law or by the State home's own policies.

(Authority: 38 U.S.C. 101, 501, 1741–1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0160)

§ 51.450 Specialized rehabilitative services.

(a) *Provision of services.* If specialized rehabilitative services such as, but not limited to, physical therapy, speech therapy, occupational therapy, and mental health services for mental illness are required in the participant's comprehensive plan of care, program management must:

(1) Provide the required services; or

(2) Obtain the required services and equipment from an outside resource, in accordance with § 52.210(h), from a provider of specialized rehabilitative services.

(b) *Written order.* Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.

(Authority: 38 U.S.C. 101, 501, 1741–1743)

§ 51.455 Dental services.

(a) If the adult day health care program offers medical supervision, program management must, if necessary, assist the participant and family/caregiver:

(1) In making appointments; and

(2) By arranging for transportation to and from the dental services.

(b) If the adult day health care program offers medical supervision, program management must promptly assist and refer participants with lost or damaged dentures to a dentist.

(Authority: 38 U.S.C. 101, 501, 1741–1743)

§ 51.460 Administration of drugs.

If the adult day health care program offers medical supervision, the program management must assist participants with the management of medication and have a system for disseminating drug information to participants and program staff in accordance with this section.

(a) *Procedures.* The State home must:

(1) Provide reminders or prompts to participants to initiate and follow through with self-administration of medications.

(2) Establish a system of records to document the administration of drugs by participants and/or staff.

(3) Ensure that drugs and biologicals used by participants are labeled in accordance with currently accepted professional principles, and include the

appropriate accessory and cautionary instructions, and the expiration dates when applicable.

(4) Store all drugs, biologicals, and controlled schedule II drugs listed in 21 CFR 1308.12 in locked compartments under proper temperature controls, permit only authorized personnel to have access, and otherwise comply with all applicable State and Federal laws.

(b) *Service consultation.* The State home must provide the services of a pharmacist licensed in the State in which the program is located who provides consultation, as needed, on all the provision of drugs.

(Authority: 38 U.S.C. 101, 501, 1741–1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0160)

§ 51.465 Infection control.

The State home must meet the requirements concerning infection control set forth in § 51.190. For purposes of this section, the references in the cited section to resident refer to a participant.

(Authority: 38 U.S.C. 501)

§ 51.470 Physical environment.

The State home must ensure that the physical environment is designed, constructed, equipped, and maintained to protect the health and safety of participants, personnel and the public.

(a) *Life safety from fire.* The State home must meet the requirements of § 51.200(a), except as to any standard in the National Fire Protection Association code that only applies to nursing homes.

(b) *Space and equipment.* (1) The State home must—

(i) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide participants with needed services as required by these standards and as identified in each participant's plan of care; and
(ii) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

(2) Each adult day health care program of care, when it is co-located in a nursing home, domiciliary, or other care facility, must have its own separate designated space during operational hours.

(3) The indoor space for adult day health care must be at least 100 square feet per participant including office space for staff and must be 60 square feet per participant excluding office space for staff.

(4) Each program of care will need to design and partition its space to meet its

own needs, but the following functional areas must be available:

(i) A dividable multipurpose room or area for group activities, including dining, with adequate table-setting space.

(ii) Rehabilitation rooms or an area for individual and group treatments for occupational therapy, physical therapy, and other treatment modalities.

(iii) A kitchen area for refrigerated food storage, the preparation of meals and/or training participants in activities of daily living.

(iv) An examination and/or medication room.

(v) A quiet room (with a bed or a reclining chair), which functions to separate participants who become ill or disruptive, or who require rest, privacy, or observation. It should be separate from activity areas, near a restroom, and supervised.

(vi) Bathing facilities adequate to facilitate bathing of participants with functional impairments.

(vii) Toilet facilities and bathrooms easily accessible to people with mobility problems, including participants in wheelchairs. There must be at least one toilet for every eight participants. The toilets must be equipped for use by persons with limited mobility, easily accessible from all program areas, *i.e.*, preferably within 40 feet from that area, designed to allow assistance from one or two staff, and barrier-free.

(viii) Adequate storage space. There should be space to store arts and crafts materials, wheelchairs, chairs, individual handiwork, and general supplies. Locked cabinets must be provided for files, records, supplies, and medications.

(ix) An individual room for counseling and interviewing participants and family members.

(x) A reception area.

(xi) An outside space that is used for outdoor activities that is safe, accessible to indoor areas, and accessible to those with a disability. This space may include recreational space and garden area. It should be easily supervised by staff.

(c) *Furnishings.* Furnishings must be available for all participants. This must include functional furniture appropriate to the participants' needs. Furnishings must be attractive, comfortable, and homelike, while being sturdy and safe.

(d) *Participant call system.* The coordinator's station must be equipped to receive participant calls through a communication system from:

(1) Clinic rooms; and

(2) Toilet and bathing facilities.

(e) *Other environmental conditions.* The State home must provide a safe, functional, sanitary, and comfortable environment for the participants, staff and the public. The facility management must:

(1) Establish procedures to ensure that water is available to essential areas if there is a loss of normal water supply;

(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;

(3) Equip corridors, when available, with firmly-secured handrails on each side; and

(4) Maintain an effective pest control program so that the facility is free of pests and rodents.

(Authority: 38 U.S.C. 101, 501, 1741–1743)

§ 51.475 Administration.

For purposes of this section, the references in the cited section to nursing home and nursing home care refer to adult day health care programs and adult day health care. The State home must comply with all administration requirements set forth in § 51.210 except for the following if the adult day health care program does not offer medical supervision:

(a) *Medical director.* State home adult day health care programs are not required to designate a primary care physician to serve as a medical director, and therefore are not required to comply with § 51.210(i).

(b) *Laboratory services, radiology, and other diagnostic services.* State home adult day health care programs are not required to provide the medical services identified in § 51.210(m) and (n).

(c) *Quality assessment and assurance committee.* State home adult day health

care programs are not required to comply with § 51.210(p), regarding quality assessment and assurance committees consisting of specified medical providers and staff.

(Authority: 38 U.S.C. 501, 1741–1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0160)

§ 51.480 Transportation.

Transportation of participants to and from the adult day health care facility must be a component of the overall program of care.

(a)(1) Except as provided in paragraph (a)(2) of this section, the State home must provide for transportation to enable participants, including persons with disabilities, to attend the program and to participate in State home-sponsored outings.

(2) The veteran or the family of a veteran may decline transportation offered by the adult day health care program of care and make their own arrangements for the transportation.

(b) The State home must have a transportation policy that includes procedures for routine and emergency transportation. All transportation (including that provided under contract) must be in compliance with such procedures.

(c) The State home must ensure that the transportation it provides is done by drivers who have access to a device for two-way communication.

(d) All systems and vehicles used by the State home to comply with this section must meet all applicable local, State and federal regulations.

(e) The State home must ensure that the care needs of each participant are addressed during transportation furnished by the home.

(Authority: 38 U.S.C. 101, 501, 1741–1743)

PART 52—[REMOVED]

■ 8. Remove part 52.

[FR Doc. 2015–13838 Filed 6–16–15; 8:45 am]

BILLING CODE 8320–01–P