DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
801 Market Street, Suite 9400
Philadelphia, Pennsylvania 19107-3134

Region III/Division of Medicaid and Children's Health Operations

SWIFT # 082020184016

December 31, 2018

Melisa Byrd
Medicaid Director
Department of Health Care Finance
441 4th Street, N.W., 9th floor, South
Washington, D.C. 20001

Dear Ms. Byrd:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the District of Columbia's State Plan Amendment (SPA) 18-0007, Health Homes My GPS Amendment. This SPA proposes to update the Health Homes Payment Methodologies.

We are pleased to inform you that, after extensive review, this amendment is approved; its effective date is December 1, 2018.

If you have any further questions regarding this SPA, please contact Dan Belnap of my staff at 215-861-4273 or dan.belnap@cms.hhs.gov.

Sincerely,

Teia N. Miller -S Digitally signed by Teia N. Miller -S Date: 2018.12.31 14:16:20 -05'00'

Teia Miller

Acting Associate Regional Administrator

cc: Alice Weiss, DHCF
Eugene Simms, DHCF
Sabrina Tillman Boyd, CMS

DC - Submission Package - DC2018MS0003O - (DC-18-0007) - Health Homes

CMS-10434 OMB 0938-1188

Package Information

Package ID	DC2018MS0003O	**Submission Type**	Official
Program Name	My Health GPS	**State**	DC
SPA ID	DC-18-0007	**Region**	Philadelphia, PA
Version Number	2	**Package Status**	Approved
Submitted By	Eugene Simms	**Submission Date**	8/17/2018
Package Disposition		**Approval Date**	12/31/2018 11:47 AM EST
Priority Code	P2		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | DC2018MS0003O | DC-18-0007 | My Health GPS

Package Header

Package ID DC2018MS0003O

SPA ID DC-18-0007

Submission Type Official

Initial Submission Date 8/17/2018

Approval Date 12/31/2018

Effective Date N/A

Superseded SPA ID N/A

State Information

State/Territory Name: District of Columbia

Medicaid Agency Name: Department of Health Care Finance

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

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SPA ID and Effective Date

SPA ID DC-18-0007

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
No items available		

Submission - Summary

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Executive Summary

Summary Description Including Goals and Objectives

The My Health GPS program is established as a District-wide Health Home program under the authority of Section 1945 of the Social Security Act for District Medicaid beneficiaries who have three (3) or more chronic conditions. DHCF decided to establish the My Health GPS program as a second health home initiative in recognition of the unmet care management needs of Medicaid beneficiaries with multiple chronic conditions. Historically, many of these beneficiaries have not received comprehensive care management services and their care has largely gone unmanaged, resulting in the preventable utilization of fire and emergency medical services, avoidable emergency department services and hospital admissions, and poor health outcomes. In order to meet the healthcare needs of this vulnerable population, the comprehensive care management services offered through the My Health GPS program will be delivered by an interdisciplinary team embedded in the primary care setting, which will coordinate patient-centered and population-focused care for these beneficiaries.

In order to improve the quality of My Health GPS services DHCF is proposing amendments to the My Health GPS program's beneficiary risk adjustment criteria, quality provisions, and reimbursement methodology: 1) DHCF is proposing amendments to the risk stratification process to determine the acuity tier of additional high-need groups whose complexity is not fully captured by the nationally-recognized risk stratification tool; 2) DHCF is proposing the establishment of a third PMPM rate to support the initial development of the person-centered care plan and annual evaluation and revision of the person-centered care plan; 3) DHCF is delaying implementation of the the pay-for-performance program and instead will begin awarding performance payments in fiscal year (FY) 2021 based on a My Health GPS entity's performance in FY 2020; and 4) DHCF is proposing amendments to explicitly include the provision of support to children transitioning from a pediatric practice to an adult practice as a My Health GPS service.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2019	$-3910658
Second	2020	$-2512424

Federal Statute / Regulation Citation

1945 of the Social Security Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

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Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe As part of the District State Plan Amendment development process, the Mayor's Office is informed of and has the opportunity to provide feedback on all State Plan Amendments prior to submission to CMS. Any feedback received from the Executive Office of the Mayor is reflected in this submission.

Submission - Public Comment

MEDICAID | Medicaid State Plan | Health Homes | DC2018MS0003O | DC-18-0007 | My Health GPS

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Name of Health Homes Program

My Health GPS

Indicate whether public comment was solicited with respect to this submission.

- ○ Public notice was not federally required and comment was not solicited
- ○ Public notice was not federally required, but comment was solicited
- ◉ Public notice was federally required and comment was solicited

Indicate how public comment was solicited:

- ☐ Newspaper Announcement
- ☐ Publication in state's administrative record, in accordance with the administrative procedures requirements

Date of Publication: Nov 23, 2018

- ☐ Email to Electronic Mailing List or Similar Mechanism
- ☐ Website Notice
- ☐ Public Hearing or Meeting
- ☐ Other method

Upload copies of public notices and other documents used

Name	Date Created	
Health Care Finance Department of 29 DCMR Ch. 102 My Health GPS Program (2)	12/11/2018 11:24 AM EST	

Upload with this application a written summary of public comments received (optional)

Name	Date Created	
No items available		

Indicate the key issues raised during the public comment period (optional)

- ☐ Access
- ☐ Quality
- ☐ Cost
- ☐ Payment methodology
- ☐ Eligibility
- ☐ Benefits
- ☐ Service delivery
- ☐ Other issue

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | DC2018MS0003O | DC-18-0007 | My Health GPS

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Superseded SPA ID	N/A		

Name of Health Homes Program

My Health GPS

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

- ○ Yes
- ◉ No

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | DC2018MS0003O | DC-18-0007 | My Health GPS

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Effective Date N/A

Superseded SPA ID N/A

SAMHSA Consultation

Name of Health Homes Program

My Health GPS

☐ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation
11/10/2016

Health Homes Intro

Package Header

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Approval Date	12/31/2018	**Effective Date**	12/1/2018
Superseded SPA ID	DC-17-0003		
	System-Derived		

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

My Health GPS

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

The District of Columbia's (DC) Department of Health Care Finance (DHCF) developed DC's Health Home (HH) State Plan benefit for beneficiaries with three or more chronic conditions. The goals of DHCF's HH program for beneficiaries with three or more chronic conditions are to improve the integration of medical and behavioral health, community supports and social services; to lower rates of avoidable emergency department (ED) use; to reduce preventable hospital admissions and re-admissions; to reduce healthcare costs; to improve the experience of care, quality of life and beneficiary satisfaction; and to improve health outcomes. Under DHCF's approach, the HH will be the central point for coordinating patient-centered and population-focused care for beneficiaries with three or more chronic conditions. HH providers will be embedded in the primary care setting to effectively manage the full breadth of beneficiary needs. A beneficiary can only be enrolled and receive HH services from one HH at a time. DHCF will ensure payments to HH providers do not duplicate payments for comparable services financed by Medicaid. HH services will be consistent with, but not limited to, those set forth under 42 C.F.R. 440.169.

General Assurances

- [ ] The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- [ ] The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- [ ] The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- [ ] The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- [ ] The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- [ ] The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

Package Header

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	System-Derived		

- (•) Health Homes services will be available statewide
- ( ) Health Homes services will be limited to the following geographic areas
- ( ) Health Homes services will be provided in a geographic phased-in approach

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | DC2018MS0003O | DC-18-0007 | My Health GPS

Package Header

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Superseded SPA ID DC-17-0007

System-Derived

Payment Methodology

The State's Health Homes payment methodology will contain the following features

☐ Fee for Service

☐ Individual Rates Per Service

☐ Per Member, Per Month Rates

☐ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☐ Other

Describe below

DHCF is proposing the establishment an initial and annual PMPM rate to support the development and maintenance of the care plan for each beneficiary in Group 1 and Group 2.

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

☐ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☐ Other

Describe below

DHCF plans to implement a pay-for-performance component that provides incentive payments to HH providers for achieving quality/performance benchmarks. DHCF will ensure the methodology used to calculate and disburse incentive payments is consistent with the HH program goals of efficiency, economy and quality.

Beginning July 1, 2017 and ending October 31, 2017, HH providers will be eligible for a one time incentive payment to support the development of care plans (as described in the definition of Comprehensive Care Management) for HH beneficiaries. Further guidance on the incentive payment will be outlined in District rulemaking.

HH providers will also be eligible to receive an annual pay-for-performance bonus payment, no sooner than the last quarter of the second full Fiscal Year after the effective date of the program. Participation in the pay-for-performance program is mandatory for all enrolled HH providers. Receipt of

the performance payment is based on attainment or improvement on specified performance measures, further outlined in the DCMR.

DHCF will inform HH providers prior to the start of each
Fiscal Year the target performance for each measure, based on an analysis of prior performance. The unit of service for the performance based payments will be attainment of the 75th percentile or improvement (statistically significant) on specified performance measures.

HH providers will be subject to a percentage withhold of their PMPM, no sooner than the first quarter of the second full Fiscal Year after the effective date of the program. HH providers are eligible to earn up to 1.5 times the withhold as a performance payment. Receipt of a performance payment and the amount of the performance payment is based on a HH providers attainment or improvement on specified weighted performance measures.

To determine the HH provider's annual performance in the pay-for-performance program, DHCF shall score each participating HH provider's performance across measures separated into measurement domains. A maximum of one hundred (100) points will be awarded to each HH provider across domains. Each measure in the domain is assigned points by dividing the total points by the number of performance measures in each domain.

Points for each measure shall be awarded in cases where a HH provider meets either the attainment or improvement threshold based on the prior measurement year's performance.

The amount of the performance payment that a HH provider shall be eligible to receive shall be calculated by summing points awarded to determine domain totals, then summing domain totals to determine total performance points and dividing the total performance points by maximum allowed points to determine the performance period percentage. The performance period percentage shall be multiplied by one and one-half (1.5) times the performance period withhold amount for the HH provider.

Further guidance on the pay-for-performance component will be outlined in District rulemaking, available at: www.dcregs.dc.gov, with an effective
date of December 1, 2018.

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

DHCF will use three (3) per member per month (PMPM) rates to reimburse for HH services. HH providers will be eligible for only one PMPM rate per month consistent with guidance in District rulemaking. DHCF developed two (2) PMPM rates that differ based on the assessed acuity of the Medicaid beneficiary; a higher PMPM rate is assigned to beneficiaries with more complex needs or higher acuity. DHCF initially developed these rates by analyzing FY 2014 and 2015 Medicaid claims data to identify the most common chronic conditions associated with more frequent ER use or hospital admissions.

DHCF will utilize a risk adjustment tool and other criteria outlined in policy guidance to determine the risk for future hospital utilization and stratify the population into two acuity cohorts: Group 1 (lower risk) and Group 2 (higher risk). Individuals identified as higher risk beneficiaries will be placed in Group 2 and the remainder of eligible beneficiaries in Group 1. DHCF shall place beneficiaries in Group 1 or Group 2 consistent with processes outlined in District rulemaking

and published policy guidance.

Finally, DHCF will develop a third PMPM rate (an initial and annual payment) to support the additional cost to My Health GPS entities associated with the development and maintenance of the person-centered care plan.

The three (3) PMPM rates are based on the DHCF HH staffing model and reflect the average expected service intensity for those receiving HH services, and will be set in accordance with Section 1902(a)(30)(A) of the Social Security Act (42 U.S.C. § 1396a(a)(30)(A)).

DHCF will pay a higher PMPM rate for beneficiaries in Group 2 (higher acuity) due to a higher expected need for HH services and requisite staff. The base PMPM rates for both Group 1 (lower acuity) and Group 2 (higher acuity) account for the regionally adjusted salaries for the required HH staff (including fringe costs) and is adjusted based on staffing ratios per acuity group. Two (2) payment enhancements are added on each of the three PMPM base rates: 1) to reflect overhead or administrative costs; and 2) to support HH providers in meeting the health information technology requirements. The payment methodology and rates will be further outlined in District rulemaking. DHCF will review the HH rates annually and re-base as necessary.

The initial and annual payment to support the development and maintenance of the person centered care plan shall be developed based on HH provider team salary and fringe to determine a base rate per HH provider team member. The team member base rates shall be adjusted by a level of effort factor and totaled to determine the initial and annual care plan development payment rate. In order to receive the initial payment for the development of the care plan HH providers shall complete the following components of the person-centered plan of care in accordance with the standards for Comprehensive Care Management by 1) Conducting an in-person needs assessment; (2) Entering available clinical information and information gathered at the in-person needs assessment into the person-centered plan of care which shall include individualized goals pursuant; and (3) Retain documentation demonstrating the delivery of each of the activities described in (1) and (2) above.

In order to receive the initial PMPM payment for an eligible HH beneficiary, a HH provider must inform the HH beneficiary about available HH services, receive the beneficiary's consent to receive HH services, and begin the development of a care plan. The development of the care plan will follow standards for Comprehensive Care Management described below. HH providers must deliver at least one (1) HH service within the calendar month to the eligible HH beneficiary in order to receive a PMPM that month. For beneficiaries in Group 1, the HH service does not need to be delivered in-person for the provider to be eligible for the PMPM payment. For beneficiaries in Group 2, at least one (1) HH service needs to be delivered in-person for the provider to be eligible for the PMPM payment. Providers will submit claims via MMIS using a specific procedure code for health home services. Additionally, providers will be required to utilize a modifier on the procedure code that itemizes which of the health home services was delivered.

Any claim for program services shall be supported by written documentation in the EHR and clear instructions on minimum documentation requirements will be provided in District rulemaking. All claims for health home services will be subject to regular audits to ensure that Medicaid payments made to health home providers are consistent with efficiency, economy and quality of care, and made in accordance with federal and District conditions of payment.

Information on the PMPM rates will be made available in District rulemaking, available at: www.dcregs.dc.gov, with an effective date of November 1, 2018.

HH rates will be made available on the DHCF fee schedule at https://www.dc-medicaid.com/dcwebportal/home.

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

Package Header

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Superseded SPA ID	DC-17-0007		
	System-Derived		

Agency Rates

Describe the rates used

- ○ FFS Rates included in plan
- ◉ Comprehensive methodology included in plan
- ○ The agency rates are set as of the following date and are effective for services provided on or after that date

Health Homes Payment Methodologies

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

DHCF will use three (3) per member per month (PMPM) rates to reimburse for the provision of covered HH services in a calendar month. DHCF will develop one PMPM rate (an initial and annual payment) to support the additional cost to My Health GPS entities associated with the development and maintenance of the person-centered care plan. DHCF will develop two PMPM rates that differ based on the assessed acuity of the Medicaid beneficiary. DHCF developed these PMPM rates by analyzing FY 2014 and 2015 Medicaid claims data to identify the most common chronic conditions associated with more frequent ER use and/or hospital admissions. Through the analysis, DHCF identified the top sixteen (16) chronic conditions, which include: mental health conditions (depression, personality disorders); substance use disorders; asthma (+COPD); diabetes; heart disease (DCHF, conduction disorders/cardiac dysrhythmias, myocardial infarction, pulmonary heart disease); BMI over 25 (morbid obesity only); cerebrovascular disease; chronic renal failure [on dialysis]; hepatitis; HIV; hyperlipidemia; hypertension; malignancies; paralysis; peripheral atherosclerosis; and sickle cell anemia. DHCF will utilize a risk adjustment tool to determine the risk for future hospital utilization, and target and stratify the population into two acuity cohorts: Group 1 (lower risk) and Group 2 (higher risk). The methodology will be used to place the higher risk beneficiaries in Group 2 and the remainder of eligible beneficiaries in Group 1. The three (3) PMPM rates are based on the DHCF HH staffing model and reflect the average expected service intensity for those receiving HH services, and will be set in accordance with Section 1902(a)(30)(A) of the Social Security Act (42 U.S.C. § 1396a(a)(30)(A)).

DHCF will pay a higher PMPM rate for beneficiaries in Group 2 (higher acuity) due to a higher expected need for HH services and requisite staff. The base PMPM rates for both Group 1 (lower acuity) and Group 2 (higher acuity) account for the regionally adjusted salaries for the required HH staff (including fringe costs) and is adjusted based on staffing ratios per acuity group. Two (2) payment enhancements are added on top of each of the three PMPM base rates: 1) to reflect overhead or administrative costs; and 2) to support HH providers in meeting the health information technology (HIT) requirements. An HIT add-on of $5.00 is included as a component of the three (3) PMPM rates. The HIT add-on reflects the reasonable costs for HH providers in procuring, using, maintaining, or modifying health information technology as necessary to complete their care coordination work under the HH program.

The initial and annual payment to support the development and maintenance of the person centered care plan shall be developed based on HH provider team salary and fringe to determine a base rate per HH provider team member. The team member base rates shall be adjusted by a level of effort factor and totaled to determine the initial and annual care plan development payment rate. In order to receive the initial payment for the development of the care plan HH providers shall complete the following components of the person-centered plan of care in accordance with the standards for Comprehensive Care Management by 1) Conducting an in-person needs assessment; (2) Entering available clinical information and information gathered at the in-person needs assessment into the person-centered plan of care which shall include individualized goals pursuant; and (3) Retain documentation demonstrating the delivery of each of the activities described in (1) and (2) above.

In order to receive the initial PMPM payment for an eligible HH beneficiary, a HH provider must inform the HH beneficiary about available HH services, receive the beneficiary's consent to receive HH services, and begin the development of a care plan. The development of the care plan will follow standards for Comprehensive Care Management described below. HH providers must deliver at least one (1) HH service within the calendar month to the eligible HH beneficiary in order to receive a PMPM that month. For beneficiaries in Group 1, the HH service does not need to be delivered in-person for the provider to be eligible for the PMPM payment. For beneficiaries in Group 2, at least one (1) HH service needs to be delivered in-person for the provider to be eligible for the PMPM payment. Providers will submit claims via MMIS using a specific procedure code for health home services. Additionally, providers will be required to utilize a modifier on the procedure code that itemizes which of the health home services was delivered.

Any claim for program services shall be supported by written documentation in the EHR and provide clear instructions on minimum documentation requirements in District rulemaking. All claims for health home services will be subject to regular audits to ensure that Medicaid payments made to health home providers are consistent with efficiency, economy and quality of care, and made in accordance with federal and District conditions of payment.

Information on the PMPM rates will be made available in District rulemaking, available at: www.dcregs.dc.gov, with an effective date of December 1, 2018.

HH rates will be made available on the DHCF fee schedule at https://www.dc-medicaid.com/dcwebportal/home.

Health Homes Payment Methodologies

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Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved

DHCF will ensure that HH service payments will not duplicate payment for Medicaid-funded services offered through another method (i.e. managed care, 1915(c) waivers, any future HH state plan benefits, and other state plan services). DHCF will utilize District rulemaking, provider guidance materials, and MOAs to clarify roles of providers offering similar services to promote a complementary system of services that advances whole-person care and ensures non-duplication of payment or services. In instances of known duplication, DHCF will leverage its Medicaid Management Information System (MMIS) to systematically restrict duplicative provider payments. Programs with services similar to HH and DHCF's strategy to address them are outlined below.

DC has two 1915(c) waivers, the Elderly and Persons with Physical Disabilities (EPD) Waiver and the Individuals with Intellectual and Developmental Disabilities (IDD) Waiver. Both waivers provide Medicaid-reimbursable case management services. Currently, EPD case managers receive reimbursement to develop and execute a person-centered care plan for beneficiaries enrolled in the EPD Waiver program. Functions provided by EPD case managers also include assessments to determine unmet needs related to waiver services, planning of services provided under the waiver, submission of requests for the authorization of waiver services, and monitoring of service provision. Similarly, IDD service coordinators currently receive reimbursement to coordinate and facilitate the provision of quality services and supports, review the implementation and delivery of services and supports identified in the Individual Support Plan (ISP), take corrective action as necessary, assist with problem solving, and advocate for the person and his/her family. To prevent duplication of services, DHCF will establish a process to ensure beneficiaries receiving case management services from the EPD or IDD waiver will not concurrently receive HH services.

HH services will add to, and not duplicate, the clinical care coordination services provided under the Adult Substance Abuse Rehabilitative Services (ASARS) Medicaid State Plan benefit, where clinical coordinators focus on ways to ensure care plans include services that address a beneficiary's substance use disorder. To prevent duplication of services, DHCF will establish a process to ensure HH providers coordinate and collaborate with the ASARS providers and leverage their work in order to advance the "whole-person" approach to care and supports the beneficiary's full array of clinical and non-clinical health care needs.

HHs will partner with DC Medicaid MCOs through MOAs containing clearly defined roles and responsibilities for each party. Additional guidance will be supplied to HHs and MCOs in District rulemaking and MCO contracts in order to avoid duplicative efforts and to ensure timely communication, care transition planning, use of evidence-based referrals, and follow-up consultations with appropriate health service providers. HHs will include the MCO, as appropriate, when creating or updating the HH care plan. The HHs and MCOs will be expected to develop protocols for sharing information on care planning and patient care. HHs will identify any gaps in service needs for HH enrolled beneficiaries regardless of the programs from which the beneficiaries receive services.

When applicable to a particular HH provider that is otherwise reimbursed for providing care management or coordination services, DHCF will prevent duplicative payments by furnishing a differential payment to that provider, reducing payment by the amount of the duplicative service. Additionally, a beneficiary may not be enrolled in more than one HH in a given month.

DHCF does not cover targeted case management services under 1915(g). As such, there is no risk of duplication of payment for targeted case management services.

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
HH2 PMPM Rates_CMS_Subm_8_15_18	8/15/2018 5:40 PM EDT	

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | DC2018MS0003O | DC-18-0007 | My Health GPS

Package Header

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	System-Derived		

Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Comprehensive care management (CCM) is the creation, documentation, execution, and updating of a person-centered plan of care. CCM services address stages of health and disease to maximize current functionality and prevent beneficiaries from developing additional chronic conditions and complications. These services include, but are not limited to conducting a comprehensive biopsychosocial needs assessment to determine the risks and whole-person service needs and lead the HH team through the collection of behavioral, primary, acute and long-term care information from all health and social service providers (e.g. from existing MHRS Diagnostic Assessments and individual service plans; physical assessments from other PCPs; hospital discharge planners; etc.) to create a person-centered, continuous, and integrated HH care plan for every enrolled beneficiary. HHs will use a strengths-based approach in developing the HH care plan that identifies the positive attributes of the beneficiary, which includes assessing his/her strengths and preferences health and social services, and end of life planning. Each HH team will update the care plan for each empaneled beneficiary at set intervals (as detailed in District rulemaking), whenever there has been a significant change in condition, and following an unplanned inpatient stay. The HH team will monitor the beneficiary's health status, engage the beneficiary in HH services and their own care, and progress toward goals in the care plan documenting changes and adjusting the plan as needed. The HH care plan is created and updated in the HH's certified EHR technology, along with documented activities completed to create and maintain the HH care plan. Many activities of this HH component may be provided by any HH team member, but are driven by protocols and guidelines developed by the Nurse Care Manager or comparable health care professional.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All HH providers will be required to utilize a certified EHR technology which will allow providers to report and review an HH beneficiary's intake, assessment results, assigned HH team, integrated HH care plans, clinical baselines and data related to chronic conditions, as well as HH services provided, such as referrals made and health promotion activities completed. HHs will be responsible for establishing an informed consent process, including a process for obtaining consent to share patient data across the HH provider continuum. Additionally:

- HHs will be required to utilize CRISP, or other HIE services as directed by DHCF, to receive hospital event alerts (e.g. emergency department visits; hospital admissions, transfers and discharges) that will help HHs create a person-centered HH care plan.
- HHs may have access to a Dynamic Patient Care Profile tool currently being developed through CMS Implementation Advanced Planning Document (IAPD) funding support. The tool will be an "on-demand" document made available to Meaningful Use Eligible Providers (EP) and Eligible Hospitals (EH), in addition to members of their care team, that would display an aggregation of critical data (both clinical and administrative) for a selected patient.
- HHs may have access to Electronic Clinical Quality Measurement Tool and Dashboard, an electronic clinical quality measurement (eCQM) tool to route inbound Continuity of Care documents (CCD) (as outlined in 2015 Edition Health Information Technology Certification Criteria, 2015 Edition Base Electronic Health Record Definition, and ONC Health IT Certification Program Modifications or subsequent releases) from eligible Medicaid hospitals and practices to support required quality calculations and reporting; develop a population-level dashboard accessible by EPs and EHs for patient panel management.
- HHs may have access to an Analytical Patient Population Dashboard, also being developed with support from IAPD funds to enable EPs and EHs to perform panel-level analysis on their associated patient populations
- HHs are expected to share structured data utilizing Consolidated Clinical Document Architecture (C-CDA) (as outlined in 2015 Edition Health Information Technology Certification Criteria, 2015 Edition Base Electronic Health Record Definition, and ONC Health IT Certification Program Modifications or subsequent releases) or other certified data exchange standards to a designated HIE entity(ies) in the District.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians

☐ Nutritionists

☐ Other (specify)

Provider Type	Description
FQHCs; Clinical Practices and Clinical Group Practices	Many activities of this HH component may be provided by any HH team member, but are driven by protocols and guidelines developed by the Nurse Care Manager or comparable health care professional.

Care Coordination

Definition

Care coordination is the implementation of the HH care plan through appropriate linkages, referrals, coordination and follow-up to needed services and support. Care coordination includes, but is not limited to:

- appointment scheduling and providing telephonic reminders of appointments;
- assisting the beneficiary in navigating health, behavioral health, and social services systems, including housing as needed;
- community-based outreach and follow-up, including face-to-face contact with beneficiaries in settings in which they reside, which may include shelters, streets or other locations for unsheltered persons;
- telephonic outreach and follow-up to beneficiaries who do not require face-to-face contact;
- ensuring that all regular screenings are conducted through coordination with the primary care or other appropriate providers;
- assisting with medication reconciliation;
- assisting with arrangements such as transportation, directions and completion of durable medical equipment requests;
- obtaining missing records and consultation reports;
- encouraging the beneficiary's decision-making and continued participation in HH care plan;
- participating in hospital and emergency department transition care;
- documentation in the certified EHR technology;
- Ensuring that beneficiary is connected to and maintains eligibility for any public benefits to which the beneficiary may be entitled, including Medicaid; and
- Providing support to children transitioning from a pediatric practice to an adult practice.

HHs will have partnerships with DC Medicaid MCOs, primary care providers, specialists, and behavioral health providers, as well as community based organizations. Within these partnerships, the roles and responsibilities for each party will be clearly defined, and guided by District rulemaking, in order to avoid duplicative efforts, and to ensure timely communication, use of evidence-based referrals, and follow-up consultations. HHs will ensure that screenings appropriate for specific chronic conditions are conducted through coordination with the appropriate providers.

Care coordination services may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the Nurse Care Manager or comparable health care professional, in collaboration with any other appropriate health care professional (e.g. the beneficiary's mental health and substance use disorder (SUD) practitioners).

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

HHs will use their certified EHR technology to report and review referrals made to outside providers, social and community resources and individual and family supports. Through this system, HHs will have access to each beneficiary's historical service utilization which will allow better tracking of the beneficiary's needs, services received, and the identification of opportunities for improved care coordination.

To enable critical information exchange, all HHs will utilize CRISP, or other HIE services as directed by DHCF, to receive hospital event alerts (e.g. emergency department visits; hospital admissions, transfers and discharges) and both generate and receive continuity of care information. Additionally, HHs may be able to benefit from the historical information (updated in near real-time) through the Dynamic Patient Care Profile and the capabilities in the Analytical Patient Population Dashboard to inform the care coordination services delivered.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Provider Type	Description

Provider Type	Description
FQHCs; Clinical Practices and Clinical Group Practices	Care coordination services may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the Nurse Care Manager or comparable health care professional, in collaboration with any other appropriate health care professional (e.g. the beneficiary's mental health and substance use disorder (SUD) practitioners).

Health Promotion

Definition

Health promotion is the provision of health education to the beneficiary (and family member/significant other when appropriate) specific to his/her chronic conditions or needs as identified in his/her HH care plan. This service includes, but is not limited to, assistance with medication reconciliation and provides assistance for the beneficiary to develop a self-management plan, self-monitoring and management skills and promotion of a healthy lifestyle and wellness (e.g. substance abuse prevention; smoking prevention and cessation; nutrition counseling; increasing physical activity; etc.). Health promotion may also involve connecting the beneficiary with peer/recovery supports including self-help/self-management and advocacy groups, providing support for improving a beneficiary's social network, and educating the beneficiary about accessing care in appropriate settings. Health promotion may also involve the assessment of the beneficiary's understanding of their health conditions and motivation to engage in self-management, and using coaching and evidence-based practices such as motivational interviewing to enhance understanding and motivation to achieve health and social goals. HH team members will document the results of health promotion activities (e.g. beneficiary requesting additional nutrition counseling; beneficiary selecting a date to quit smoking; successful linkage with a community-based support group) in the beneficiary's care plan, and ensure health promotion activities align with the beneficiary's stated health and social goals. Each HH will use data to identify and prioritize particular areas of need with regard to health promotion; research best-practice interventions; implement the activities in group and individual settings; evaluate the effectiveness of the interventions, and modify them accordingly.
Health promotion services may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the Nurse Care Manager or comparable health care professional in collaboration with the beneficiary's mental health and substance use disorder (SUD) practitioners.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All HHs will use their certified EHR technology to document, review, and report health promotion services delivered to each beneficiary. Additionally, clinical data such as height, weight and BMI will be recorded and reported in the certified EHR technology. Additionally, structured data shared through C-CDAs or C-CDA equivalent approaches and the capabilities of the Analytical Patient Population Dashboard holds the potential to support health promotion activities of HH providers.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
FQHCs; Clinical Practices and Clinical Group Practices	Health promotion services may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the Nurse Care Manager or comparable health care professional in collaboration with the beneficiary's mental health and substance use disorder (SUD) practitioners.

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care is the planned coordination of transitions between health care providers and settings in order to reduce hospital emergency department and inpatient admissions, readmissions and length of stay. An aim of comprehensive transitional care is to increase the beneficiary's and family members' ability to manage care and live safely in the community, shifting the use of reactive or emergency care and treatment to proactive health promotion and self-management. HHs will automatically receive notifications of emergency room visits, admissions, discharges and transfers (ADT) from hospitals as part of HHs' enrollment in CRISP, and will contact hospitals from which notifications are received to ensure appropriate follow-up care after transitions. HHs will conduct in-person outreach prior to discharge or up to twenty-four (24) hours after discharge to support transition from inpatient to other care settings. They will schedule visits for beneficiaries with a primary care provider and/or specialist within one (1) week of discharge. HHs will have a clear protocol for responding to

ADT alerts from hospitals or any other inpatient facility to facilitate collaboration in treatment, discharge, and safe transitional care. Services as part of beneficiary contacts during transitions include but are not limited to: a) reviewing the discharge summary and instructions; b) performing medication reconciliation; c) ensuring that follow-up appointments and tests are scheduled and coordinated; d) assessing the patient's risk status for readmission to the hospital or other failure to obtain appropriate, community-based care; e) arranging for follow-up care management, if indicated in the discharge plan; and f) planning appropriate care/place to stay post-discharge, including facilitating linkages to temporary or permanent housing and arranging transportation as needed for transitional care and follow-up medical appointments. This HH component is provided primarily by the Nurse Care Manager and Care Coordinator or comparable provider.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

To enable critical information exchange, all HHs will enroll with CRISP, or other HIE services as directed by DHCF, to receive hospital event alerts (e.g. emergency department visits; hospital admissions, transfers and discharges) and both generate and receive continuity of care information. MCOs also receive hospital alerts through CRISP. To the extent that hospitals and other inpatient settings have care transition programs, HHs are expected to coordinate with hospital discharge planners to prevent duplication of services and to ensure that all essential functions of an effective care transition have been performed. Additionally, HHs may benefit from the historical information (updated in near real-time) through the Dynamic Patient Care Profile, structured data shared through C-CDAs or C-CDA equivalent approaches, and the capabilities in the Analytical Patient Population Dashboard to inform transitional care efforts.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
FQHCs; Clinical Practices and Clinical Group Practices	This HH component is provided primarily by the Nurse Care Manager and Care Coordinator or comparable provider.

Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support services are activities that help the beneficiary and their support team (including family and authorized representatives) in identifying and meeting their range of biopsychosocial needs and accessing resources. These services include, but are not limited to, medical transportation, language interpretation, appropriate literacy materials, housing assistance, and any other needed services. The services provide for continuity in relationships between the beneficiary/family with their physician and other health service providers and can include communicating on the beneficiary and family's behalf. These services may also educate the beneficiary in self-management of their chronic conditions, provide opportunities for the family to participate in assessment and development of the person-centered plan of care, and ensure that HH services are delivered in a manner that is culturally and linguistically appropriate. Additionally, these services may include referrals to support services and to facilitate linkages that are available in the beneficiary's community and assist with the establishment of and connection to "natural supports." These services may promote personal independence, assist and support the beneficiary in stressor situations, empower the beneficiary to improve their own environment, include the beneficiary's family in the quality improvement process including surveys to capture their experience with HH services, and allow beneficiaries/families access to electronic health record information or other clinical information. Where appropriate, the HH will develop family support materials and services, including creating family support groups.
This HH component is provided by any member of the HH team, but will be primarily facilitated by the Care Coordinator or comparable provider, in line with the beneficiary's care plan, and driven by protocols and guidelines developed by the Nurse Care Manager or comparable provider.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All HHs will use their certified EHR technology, to document, review, and report family support services delivered to each beneficiary. Additionally, HHs may benefit from the historical information (updated in near real-time) through the Dynamic Patient Care Profile and the capabilities in the Analytical Patient Population Dashboard to inform individual and family support efforts.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner

- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
FQHCs; Clinical Practices and Clinical Group Practices	This HH component is provided by any member of the HH team, but will be primarily facilitated by the Care Coordinator or comparable provider, in line with the beneficiary's care plan, and driven by protocols and guidelines developed by the Nurse Care Manager or comparable provider.

Referral to Community and Social Support Services

Definition

Referral to community and social support services is the process of connecting HH beneficiaries to a wide array of support services that will help them overcome access or service barriers, increase self-management skills, and achieve overall health. These services include, but are not limited to, facilitating access to support and assistance for beneficiaries to address medical, behavioral, educational, economic, social and community issues that may impact overall health. For persons experiencing homelessness, this support may include individual housing transition services, as described in the June 26, 2015 Center for Medicaid & CHIP Services (CMCS) Informational Bulletin. The types of community and social support services to which beneficiaries will be referred may include, but are not limited to: a) wellness programs, including smoking cessation, fitness, weight loss programs; b) specialized support groups (e.g. cancer; diabetes support groups; etc.); c) substance treatment, support groups, recovery coaches, and 12-step programs; d) housing resources, including additional housing and tenancy sustaining services; e) social integration; f) financial assistance such as Temporary Cash Assistance for Needy Families (TANF) or Social Security; g) Supplemental Nutrition Assistance Program; h) employment and educational program or training; i) legal assistance resources; j) faith-based organizations; and k) child care. HHs will assist in coordinating the services listed above, facilitating linkages and helping address barriers to accessing services, and following up with beneficiaries to ensure that needed services have been received. The HH will develop and monitor cooperative agreements with community and social support agencies in order to establish collaboration, follow-up, and reporting standards and provide training and technical assistance as needed regarding the special needs of the population.
This HH component is provided by any member of the HH team, but will be primarily facilitated by the Care Coordinator, in line with the beneficiary's care plan, and driven by protocols and guidelines developed by the Nurse Care Manager or comparable provider.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All HHs will use certified EHR technology to document, report and review referrals to community-based resources. Additionally, HHs may benefit from the historical information (updated in near real-time) through the Dynamic Patient Care Profile.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
FQHCs; Clinical Practices and Clinical Group Practices	This HH component is provided by any member of the HH team, but will be primarily facilitated by the Care Coordinator, in line with the beneficiary's care plan, and driven by protocols and guidelines developed by the Nurse Care Manager or comparable provider.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | DC2018MS0003O | DC-18-0007 | My Health GPS

Package Header

Package ID	DC2018MS0003O	**SPA ID**	DC-18-0007
Submission Type	Official	**Initial Submission Date**	8/17/2018
Approval Date	12/31/2018	**Effective Date**	12/1/2018
Superseded SPA ID	DC-16-0012		
	System-Derived		

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

An eligible HH beneficiary will receive written notice from DHCF about being auto-assigned to a HH. This notice will include information about the HH program, including the beneficiary's rights under the opt-out process (i.e. assignment to a HH team, HH services are free, enrollment is optional, not enrolling does not impact current services). This notice will be supplemented by HH provider outreach, which will be initiated once DHCF communicates information about the HH program to HH and non-HH providers with past experience with the beneficiary. This notice is to help ensure the beneficiary is receiving consistent information from their network of providers. Subsequently, the beneficiary can anticipate outreach from the HH provider that will include an informed consent process. The provider must document the beneficiary's written informed consent to participate in the HH program, which the beneficiary may provide during a planned or newly scheduled visit. At that visit, the beneficiary should expect to participate in an assessment to inform the development of a comprehensive care plan. As part of this process, the beneficiary should also anticipate that the HH provider will gather health information from the beneficiary's other healthcare providers (e.g. MCOs; specialists; etc.) and conduct health risk screens (e.g. depression; substance abuse; etc.). The beneficiary should also anticipate that the Nurse Care Manager (NCM) or comparable provider and will review/discuss assessment results, health goals and health care priorities with the beneficiary during the visit. The beneficiary and multi-disciplinary HH team will agree upon and document a comprehensive HH care plan that addresses wellness and self-management goals for any assessed needs. Subsequently, the beneficiary can expect the HH team to deliver HH services that enable the beneficiary to meet the goals outlined in the care plan. Moving forward, the beneficiary should expect the HH team to work with their primary care provider and other providers as necessary; and to be linked with any additional providers if necessary. The beneficiary will be monitored daily by the HH team through reviews of hospital ADT feeds to determine if the beneficiary used the ER or was admitted to the hospital. The beneficiary will be monitored weekly by the HH team through case rounds to track progress and plan accordingly for interventions/interactions based on patient acuity and need. The beneficiary will be monitored quarterly through reviews of updated registries and care plan statuses conducted by the NCM. If the NCM identifies emerging issues warranting changes, the beneficiary should anticipate follow-up (e.g. re-assessment, revised/increased levels of activity). Beneficiary issues that may trigger additional levels of activity include, but are not limited to, medication management, care compliance, outlier lab values, and progress controlling BMI levels, tobacco use, and metabolic screening values. The beneficiary should anticipate their HH care plan being updated at least every three hundred sixty-five (365) days or when there is a significant change in their condition.

Name	Date Created	
DC Patient Flow for SPA docx	10/28/2016 5:33 PM EDT	

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