

DEPARTMENT OF HEALTH CARE FINANCE**NOTICE OF SECOND EMERGENCY AND PROPOSED RULEMAKING**

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02 (2014 Repl. & 2015 Supp.) and Section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2012 Repl.)), hereby gives notice of the adoption, on an emergency basis, of a new Chapter 69 (Medicaid Reimbursement for Health Home Services), of Title 29 (Public Welfare), of the District of Columbia Municipal Regulations (DCMR).

The purpose of Chapter 69 is to establish requirements for Medicaid reimbursement for Health Home services. A Health Home is a service delivery model that focuses on providing comprehensive care coordination centered on improving the management of chronic behavioral and physical health conditions. Health Homes develop and organize person-centered care plans that facilitate access to physical health services, behavioral health care, community-based services and supports for persons determined eligible for Health Home services by the Department of Behavioral Health. Care coordination is provided through a team based approach and involves all relevant and necessary health care practitioners, family members, and other social support networks identified by the beneficiary. The Health Home is required to provide all Health Home services needed by its beneficiaries. The goal of the Health Home service delivery model is to reduce avoidable health care costs, specifically preventable hospital admissions, readmissions, and avoidable emergency room visits for the enrolled Health Home population.

Health Home services are Medicaid reimbursable at a per member/per month (PMPM) rate. These rules establish the reimbursement rate and requirements for reimbursement for the provision of Health Home services.

Emergency action is necessary for the immediate preservation of health, safety, and welfare of beneficiaries who are in need of comprehensive care coordination through the Medicaid Health Home State Plan benefit. The Health Home reimbursement rates included in these rules are needed at this time to ensure that Health Home providers receive payment for Health Home services delivered, and to ensure that Health Home providers can continue to deliver the level of Health Home services that beneficiaries require. To preserve beneficiaries' health, safety, and welfare, and to avoid any lapse in access to Health Home services, it is necessary that these rules be published on an emergency basis.

A Notice of Emergency and Proposed Rulemaking was published in the *D.C. Register* on January 8, 2016 at 63 DCR 000456. No comments were received but substantive changes have been made. A new Subsection 6901.6 has been added to Section 6901 requiring that all services meet quality standards or guidelines that adhere to applicable National Committee for Quality Assurance (NCQA); Centers for Medicare and Medicaid Services (CMS); and Department of

Health Care Finance (DHCF) guidance related to quality improvement activities. Subsection 6903.4 is amended to change the record retention requirement from six (6) years to ten (10) years, consistent with the provisions set forth in the Medicaid provider agreement. Finally, Section 6904 governing Audits and Review has been amended to reflect the current process for requesting an administrative review and appeal.

The emergency rulemaking was adopted on April 18, 2016 and became effective on that date. The emergency rules shall remain in effect for one hundred and twenty (120) days or until August 16, 2016, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*. The Director gives notice of the intent to take final rulemaking action to adopt these proposed rules in not less than thirty (30) days after the date of publication of this notice in the *D.C. Register*.

Title 29 DCMR, PUBLIC WELFARE, is amended by adding a new Chapter 69 to read as follows:

CHAPTER 69 MEDICAID REIMBURSEMENT FOR HEALTH HOME SERVICES

6900 GENERAL PROVISIONS

- 6900.1 The purpose of this chapter is to establish standards governing Medicaid reimbursement for Health Home services provided by Core Services Agencies (CSA) certified as Health Homes by the Department of Behavioral Health (DBH).
- 6900.2 A Health Home serves as the service coordinating entity for services offered to a beneficiary with a serious mental illness (SMI).
- 6900.3 Each Health Home shall comply with the certification standards set forth in 22-A DCMR § 2501.
- 6900.4 Each Health Home shall comply with all applicable provisions of District and federal law and rules pertaining to Title XIX of the Social Security Act, and all District and federal law and rules applicable to the service or activity provided pursuant to these rules.
- 6900.5 In accordance with Section 1902(a)(23) of the Social Security Act, DBH shall ensure that each beneficiary has free choice of qualified providers.

6901 PROGRAM SERVICES

- 6901.1 Beneficiaries eligible to receive Health Home services shall be Medicaid beneficiaries who meet the requirements set forth in 22-A DCMR § 2504.
- 6901.2 Beneficiaries enrolled in both the Medicaid Elderly and Individuals with Physical Disabilities (EPD) Waiver and a Health Home, shall receive Comprehensive Care Management services, as described in 22-A DCMR § 2506, from a Health Home.

- 6901.3 Health Home services include the following services, as set forth in 22-A DCMR § 2505, and further defined in 22-A DCMR §§ 2506 – 2511:
- (a) Comprehensive Care Management;
 - (b) Care Coordination;
 - (c) Comprehensive Transitional Care;
 - (d) Health Promotion;
 - (e) Individual and Family Support Services; and
 - (f) Referral to Community and Social Support Services.
- 6901.4 DBH shall assign each beneficiary eligible to receive Health Home services into either a high- or low-acuity category as set forth in 22-A DCMR § 2514.
- 6901.5 Each Health Home provider shall provide the following services each month to every Health Home beneficiary:
- (a) To a high-acuity beneficiary, defined in 22-A DCMR § 2514.2:
 - (1) Two (2) Comprehensive Care Management services which include activities listed in 22-A DCMR § 2506.2;
 - (2) At least two (2) other Health Home services of any kind, as described in 22-A DCMR § 2507, § 2508, § 2509, § 2510 and § 2511; and
 - (3) At least one (1) of the services must be provided as a face-to-face service.
 - (b) To a low-acuity beneficiary, defined in 22-A DCMR § 2514.3:
 - (1) One (1) Comprehensive Care Management Services per month which include activities listed in 22-A DCMR § 2506.2; and
 - (2) At least one (1) other Health Home service of any kind, as described in 22-A DCMR § 2507, § 2508, § 2509, § 2510 and § 2511.
- 6901.6 All services provided as described in Section 6901 of this chapter, and in 22-A DCMR §§ 2500, *et seq.*, shall meet quality standards or guidelines that adhere to applicable National Committee for Quality Assurance (NCQA); Centers for

Medicare and Medicaid Services (CMS); and Department of Health Care Finance (DHCF) guidance related to quality improvement activities.

6902 REIMBURSEMENT

6902.1 Medicaid reimbursement for Health Home services is on a per member/per month (PMPM) reimbursement schedule. The month time period shall begin on the first (1st) of the month and end on the last day of the month.

6902.2 Health Homes are required to provide services in accordance with § 6901.4, and document the delivery of these services in DBH’s electronic record system called iCAMS, in order to receive the PMPM reimbursement rate.

6902.3 In order to qualify for the monthly rate, Health Homes shall document Health Home services provided as set forth in 22-A DCMR § 2515.3 and §§ 2516.3 – 4.

6902.4 Health Homes shall not bill the beneficiary or any member of the beneficiary’s family for Health Home services. Health Homes shall bill all known third-party payors prior to billing the Medicaid Program.

6902.5 Medicaid reimbursement for Health Home services shall be determined as follows:

SERVICE	CODE	BILLABLE UNIT OF SERVICE	RATE EFFECTIVE JAN. 1, 2016
Health Home Services: High-Acuity	S0281U1	Month	\$481.00
Health Home Services: Low-Acuity	S0281U2	Month	\$349.00

6902.6 DBH shall be responsible for payment of the District’s share or the local match for Health Home services. DHCF shall claim the federal share of financial participation for Health Home services.

6902.7 Medicaid reimbursement for Health Homes is not available for:

- (a) Room and board costs;
- (b) Inpatient services (including hospital, nursing facility services, Intermediate Care Facilities for Individuals with Intellectual Disabilities, and Institutions for Mental Diseases services);
- (c) Transportation services;

- (d) Vocational services;
- (e) School and educational services;
- (f) Socialization services;
- (g) Services which are not provided and documented in accordance with DBH-established Health Home service-specific standards; and
- (h) A person who is receiving Assertive Community Treatment (ACT) services.

6902.8 Only one Health Home will receive payment for delivering Health Home services to a beneficiary in a particular month.

6902.9 A Health Home may not bill Mental Health Rehabilitation Services (MHRS) Community Support for a beneficiary enrolled in a Health Home as set forth in 22-A DCMR § 2515.2.

6903 HEALTH HOME RECORD RETENTION, PROTECTION AND ACCESS

6903.1 Health Home records shall contain sufficient information which readily identifies and supports Medicaid billing. As set forth in 22-A DCMR § 2516.3, Health Homes shall document each Health Home service and activity in the beneficiary's iCAMS record. Any claim for Health Home services shall be supported by written documentation which clearly identifies the following:

- (a) The specific service type rendered;
- (b) The date, duration, and actual time including the beginning and ending time, during which the services were rendered;
- (c) The name, title, and credentials of the person providing the services;
- (d) The setting in which the services were rendered;
- (a) A confirmation that the services delivered are contained in the beneficiary's comprehensive care plan;
- (b) Identification of any further actions required for the beneficiary's well-being raised as a result of the service provided;
- (f) A description of each encounter or service by the Health Home team member which is sufficient to document that the service was provided in accordance with this chapter; and

(g) Dated and authenticated entries, with their authors identified, which are legible and concise, including the printed name and the signature of the person rendering the service, diagnosis and clinical impression recorded in the terminology of the ICD-9 CM (or its subsequent revision), and the service provided.

6903.2 Each Health Home shall establish procedures for safeguarding beneficiary information pursuant to 42 C.F.R. § 431.305, and shall ensure, that except as otherwise provided by federal or District law or rules, the use or disclosure of beneficiary information shall be restricted to purposes related to the administration of the Medicaid Program, as set forth in 42 C.F.R. § 431.302.

6903.3 Each Health Home shall allow appropriate DHCF personnel and other authorized agents of the District of Columbia government and the federal government full access to Health Home records.

6903.4 Each Health Home shall maintain all records, including, but not limited to, financial records, medical and treatment records, and other documentation pertaining to costs, billings, payments received and made, and services provided, for ten (10) years or until all audits are completed, whichever is longer.

6903.5 In addition to the Health Home service documentation standards listed in §6903.1, a Health Home that is a public entity shall also maintain all documentation pertaining to costs necessary to perform cost reconciliation in accordance with OMB Circular A-87.

6904 AUDITS AND REVIEWS

6904.1 This section sets forth the requirements for audits and reviews of Health Home services. DHCF shall perform regular audits of Health Home providers to ensure that Medicaid payments are consistent with efficiency, economy and quality of care, and made in accordance with federal and District conditions of payment. The audits shall be conducted at least annually and when necessary to investigate and maintain program integrity. DHCF may delegate the authority contained herein to DBH pursuant to a written memorandum of agreement. Any written memorandum of agreement shall require that DBH comply with the provisions of this section as DHCF's designee.

6904.2 DHCF shall perform routine audits of claims, by statistically valid scientific sampling, to determine the appropriateness of Health Home services rendered and billed to Medicaid to ensure that Medicaid payments can be substantiated by documentation that meets the requirements set forth in this rule, and made in accordance with federal and District rules governing Medicaid.

- 6904.3 If DHCF determines that claims are to be denied, DHCF shall recoup those monies erroneously paid to a Health Home for denied claims, following the period of Administrative Review as set forth in this rule.
- 6904.4 DHCF shall issue a Proposed Notice of Medicaid Overpayment Recovery (PNR) to the Health Home, which sets forth the reasons for the recoupment, the amount to be recouped, and the procedures and timeframes for requesting an Administrative Review of the PNR.
- 6904.5 The Health Home will have thirty (30) calendar days from the date of the PNR to request an Administrative Review. The provider shall submit documentary evidence and/or written argument against the proposed action to DHCF in the request for an Administrative Review. If the provider fails to respond within thirty (30) calendar days, DHCF shall issue a Final Notice of Medicaid Overpayment Recovery (FNR), which shall include the procedures and timeframes for requesting an appeal.
- 6904.6 DHCF shall review the documentary evidence and/or written argument submitted by the Health Home against the proposed action described in the PNR. After this review, DHCF may cancel its proposed action, amend the reasons for the proposed recoupment and/or adjust the amount to be recouped. DHCF shall issue a FNR, which shall include the procedures and timeframes for requesting an appeal.
- 6904.7 Within fifteen (15) calendar days from date of the FNR, the Health Home may appeal the FNR by filing a written notice of appeal from the determination of recoupment with the Office of Administrative Hearings. The written notice requesting an appeal shall include a copy of the FNR, description of the item to be reviewed, the reason for review of the item, the relief requested, and any documentation in support of the relief requested.
- 6904.8 In lieu of the off-set of future Medicaid payments, the Health Home may choose to send a certified check made payable to the District of Columbia Treasurer in the amount of the funds to be recouped.
- 6904.9 Filing an appeal shall not stay any action to recover any overpayment.
- 6904.10 Each Health Home shall allow access during an onsite audit or review to DHCF, its designee, DBH, other authorized District of Columbia government officials, the Centers for Medicare and Medicaid Services (CMS), and representatives of the United States Department of Health and Human Services, to relevant records and program documentation.
- 6904.11 Each Health Home shall facilitate audits and reviews by maintaining the required records and by cooperating with the authorized personnel assigned to perform audits and reviews.

6905

DEFINITIONS

When used in this chapter, the following words shall have the meanings ascribed:

Behavioral Health Care – care that promotes the well-being of individuals by intervening and preventing incidents of mental illness, substance abuse, or other health concerns.

Comprehensive Care Plan – an individualized plan to provide health home services to address a beneficiary's behavioral and physical chronic conditions, based on assessment of health risks and the beneficiary's input and goals for improvement.

Beneficiary - a Medicaid recipient who has been determined to be eligible for the Health Home benefit, and/or who is enrolled in a Health Home.

Core Services Agency – a community-based provider that has entered into a Human Care Agreement with the Department of Behavioral Health to provide specific Mental Health Rehabilitation Services in accordance with the requirements of Chapter 34 of Title 22-A DCMR.

Department of Behavioral Health – the District of Columbia agency that regulates the District's mental health and substance abuse treatment system for adults, children, and youth.

Health Home – an entity that is certified by the District of Columbia Department of Behavioral Health as having systems in place to deliver person-centered services that coordinate a beneficiary's behavioral, primary, acute or other specialty medical health care services.

Mental Health Rehabilitation Services - palliative services provided by a Department of Behavioral Health-certified community mental health provider to beneficiaries in accordance with the District of Columbia Medicaid State Plan, the Department of Health Care Finance (DHCF)/ Department Interagency Agreement, and Chapter 34 of Title 22-A DCMR.

Serious Mental Illness – a diagnosable mental, behavioral, or emotional disorder (including those of biological etiology) which substantially impairs the mental health of the person or is of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) or its International Statistical Classification of Diseases and Related Health Problems, 9th Revision (ICD-9-CM) equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance abuse disorders, intellectual disabilities and

other developmental disorders, or seizure disorders, unless those exceptions co-occur with another diagnosable mental illness.

Comments on this proposed rulemaking shall be submitted in writing to Claudia Schlosberg, Senior Deputy Director, Department of Health Care Finance, 441 4th Street, N.W., 9th Floor, Washington, D.C. 20001, via email to DHCFPubliccomments@dc.gov, online at www.dcregs.dc.gov, or by telephone to (202) 442-9115, within thirty (30) days after the date of publication of this notice in the *D.C. Register*. Additional copies of these rules may be obtained from the above address.