DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02 (2016 Repl. & 2018 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) (2018 Repl.)), hereby gives notice of the adoption of an amendment to Chapter 8 (Free Standing Mental Health Clinics) and the addition of a new chapter, Chapter 69 (Medicaid Reimbursement for Health Home Services), to 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 service 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 (DBH). 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 rate. These rules establish the reimbursement rate and requirements for reimbursement for the provision of Health Home services. As a result of the changes, Medicaid expenditures for Health Home services are expected to decrease by $4,866,408 in fiscal year (FY) 2019 and decrease by $ 5,928,942 in FY 2020. Medicaid expenditures on Mental Health Rehabilitation Services (MHRS) are expected to increase by $6,240,236 in FY 2019 and increase by $6,903,345 in FY 2020.

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. A Notice of Second Emergency and Proposed Rulemaking was published on April 29, 2016 at 63 DCR 006684. No comments were received but DHCF made substantive changes to the Health Home program based on feedback from providers and best practices learned during the first two (2) years of implementation. A Notice of Third Emergency and Proposed Rulemaking was published on January 4, 2019 at 66 DCR 000107. DHCF received no comments and made no changes to the rulemaking.

These rules correspond to a related State Plan amendment, which was approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services on February 21, 2019 with an effective date of February 1, 2019.

The Director adopted these rules as final on June 7, 2019 and they shall become effective on the date of publication of this notice in the *D.C. Register*.

Chapter 8, FREE STANDING MENTAL HEALTH CLINICS, of Title 29 DCMR, PUBLIC WELFARE, is amended as follows:

Subsections 800.4, 800.5, and 800.6 of Section 800, GENERAL PROVISIONS, are amended as follows:

800.4 To obtain certification as a FSMHC, a FSMHC shall meet the requirements set forth in §§ 801 through 808 of this chapter.

800.5 Entities certified as a FSMHC in accordance with the requirements set forth in this chapter are eligible to apply for certification as a Health Home in accordance with the requirements set forth in 22-A DCMR §§ 2500, *et seq*.

800.6 A FSMHC that is certified as a Health Homes is eligible to receive reimbursement for the provision of Health Home services in accordance with the requirements set forth in 29 DCMR §§ 6900, *et seq*.

Subsection 802.3 of Section 802, CERTIFICATION REQUIREMENTS: GENERAL, is amended as follows:

802.3 The FSMHC shall agree that FSMHC services, as set forth in § 808.9, shall be provided under the direction of a physician, as required by § 440.90 of Title 42 of the Code of Federal Regulations. Health Home services provided by a FSMHC shall be provided in accordance with requirements set forth in 29 DCMR §§ 6900, *et seq*. and 22-A DCMR §§ 2500, *et seq*.

Subsections 808.5, 808.6, and 808.8 of Section 808, REIMBURSEMENT, are amended as follows:

808.5 The Department shall establish fees and reimburse for only those FSMHC services, as set forth in § 808.9, provided face-to-face by or under the direct supervision of a physician. Health Home services provided by a FSMHC shall be provided in accordance with the requirements set forth in 29 DCMR §§ 6900, *et seq*. and 22-A DCMR §§ 2500, *et seq*.

808.6 Treatment-related services, such as information and referral services, charting, staffing of patients, co-therapy phone crisis intervention, case management, person and agency conferences, and similar services are not reimbursable under the FSMHC benefit. FSMHCs certified as a Health Home shall be reimbursed for

the provision of Health Home services in accordance with the requirements set forth in 29 DCMR §§ 6900, *et seq.* and 22-A DCMR §§ 2500, *et seq.*

808.8 Excluding Health Home services provided in accordance with requirements set forth in 29 DCMR §§ 6900, *et seq.* and 22-A DCMR §§ 2500, *et seq.*, Medicaid shall reimburse a participating FSMHC for only one (1) type of service for a Medicaid patient on a given day; provided, that if a full prescription visit, or medication assessment visit is indicated in addition to a therapy visit, and is accomplished on the same day, both services may be billed as long as no more than one (1) billing of this type occurs in a single month. Any additional billings of this type, shall be authorized by the Department prior to the FSMHC submitting a claim for payment.

A new Chapter 69, MEDICAID REIMBURSEMENT FOR HEALTH HOME SERVICES, is added to read as follows:

CHAPTER 69 MEDICAID REIMBURSEMENT FOR HEALTH HOME SERVICES

6900 GENERAL PROVISIONS
6901 PROGRAM SERVICES
6902 REIMBURSEMENT
6903 HEALTH HOME RECORD RETENTION, PROTECTION AND ACCESS
6904 AUDITS AND REVIEWS
6905 [RESERVED]
6999 DEFINITIONS

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) and Free Standing Mental Health Clinics (FSMHCs) certified as Health Homes by the Department of Behavioral Health (DBH).

6900.2 Effective February 1, 2019, FSMHCs shall be eligible to be certified as Health Homes by DBH and be reimbursed by DHCF for the provision of Health Home services to District Medicaid beneficiaries.

6900.3 A Health Home serves as the service coordinating entity for services offered to a beneficiary with a serious and persistent mental illness.

6900.4 Each Health Home shall comply with the certification standards set forth in 22-A DCMR § 2501.

6900.5 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.

6900.6 In accordance with § 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 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.

6901.3 Effective February 1, 2019, each Health Home provider shall provide at least one (1) Health Home service of any kind, as described in 22-A DCMR §§ 2506 - 2511 to the Health Home beneficiary, each month, in order to claim the per member per month payment set forth in § 6902.6.

6901.4 All services provided as described in § 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) standards, as well as 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 approved electronic record system, 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 for dates of service prior to February 1, 2019 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 Effective February 1, 2019, Medicaid reimbursement for Health Home services shall be determined as follows:

SERVICE	CODE	BILLABLE UNIT OF SERVICE	RATE EFFECTIVE FEBRUARY 1, 2019
Health Home Services	S0281U4	Month	$125.75

6902.7 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.

6902.8 Medicaid reimbursement for Health Home services 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;

(h) A person who is receiving Assertive Community Treatment (ACT) services;

(i) Medicaid beneficiaries enrolled in the Home and Community-Based Services (HCBS) Waiver for the Elderly and Individuals with Physical Disabilities, as described in Chapter 42 of Title 29 of the DCMR;

(j) Medicaid beneficiaries enrolled in the HCBS Waiver for Persons with Intellectual and Developmental Disabilities, as described in Chapter 19 of Title 29 of the DCMR; and

(k) Medicaid beneficiaries enrolled in the *My Health GPS* program, as described in Chapter 102 of Title 29 of the DCMR.

6902.9 Only one Health Home will receive payment for delivering Health Home services to a beneficiary in a particular month.

6902.10 Effective February 1, 2018, an entity enrolled as Health Home may bill Medicaid separately for the provision of MHRS Community Support services provided to a beneficiary enrolled in a Health Home.

6902.11 DHCF shall not reimburse other Medicaid claims submitted by Health Homes that duplicate Health Home services, as described in 22-A DCMR §§ 2506 - 2511.

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 record in DBH's approved electronic record system. 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, a.m. or p.m., including the beginning and ending time, during which the services were rendered;

(c) The name, title, and credentials of the person who provided the services;

(d) The setting in which the services were rendered;

(e) A confirmation that the services delivered are contained in the beneficiary's comprehensive care plan;

(f) Identification of any further actions required for the beneficiary's well-being raised as a result of the service provided;

(g) 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

(h) 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 International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10 CM) or its subsequent revision, and the service provided.

6903.2 Each Health Home shall establish procedures for safeguarding beneficiary information pursuant to 42 CFR § 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 CFR § 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 Office of Management and Budget 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.

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 were improperly reimbursed, 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, 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 [RESERVED]

6999 DEFINITIONS

6999.1 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.

Free Standing Mental Health Clinic – an entity certified in accordance with Chapter 8 of Title 29 DCMR.

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 – behavioral health 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 of Behavioral Health Interagency Agreement, and Chapter 34 of Title 22-A DCMR.

Serious and Persistent 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 DSM-5 or its ICD-10-CM equivalent (and subsequent revisions) with the exception of DSM-5 "Z" codes, substance abuse disorders, intellectual disabilities and other developmental disorders, or seizure disorders, unless those exceptions co-occur with another diagnosable mental illness.