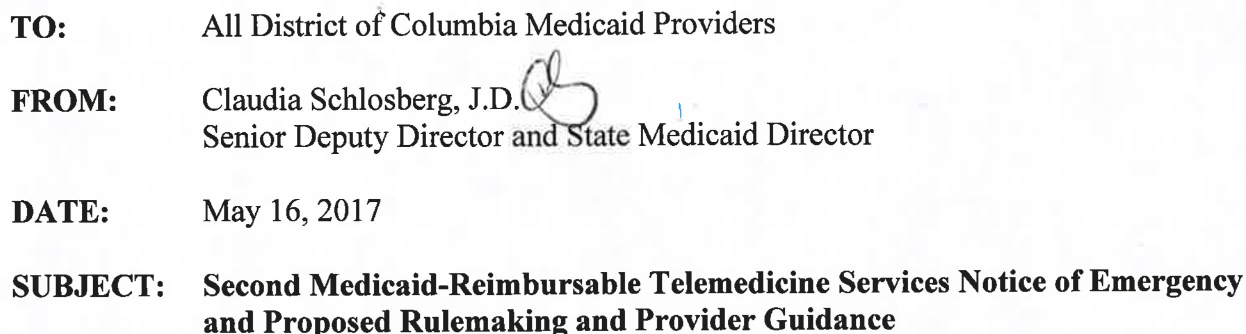
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/
Medicaid Director

Transmittal # 17-14



TO: All District of Columbia Medicaid Providers

FROM: Claudia Schlosberg, J.D.
Senior Deputy Director and State Medicaid Director

DATE: May 16, 2017

SUBJECT: **Second Medicaid-Reimbursable Telemedicine Services Notice of Emergency and Proposed Rulemaking and Provider Guidance**

The purpose of this transmittal is to notify all Medicaid providers of the second emergency and proposed rule and updated provider guidance related to Medicaid reimbursement for services delivered via telemedicine. The rule outlines the standards governing eligibility for Medicaid beneficiaries receiving healthcare services via telemedicine under the Medicaid fee-for-service program and the conditions of participation for providers who deliver healthcare services to Medicaid beneficiaries via telemedicine.

On Friday, May 5, 2017, DHCF's Second Medicaid-Reimbursable Telemedicine Services Notice of Emergency and Proposed Rulemaking was published in the DC Register. Per the notice, the emergency rulemaking was adopted on April 27, 2017 and shall become effective for eligible services rendered on or after that date. Public comments on this rule will be accepted until June 5, 2017. This rule is also located on DHCF's website at www.dhcf.dc.gov.

Please see the attached telemedicine provider guidance document for additional information on which providers are eligible to bill for services delivered via telemedicine, which services are eligible to be delivered via telemedicine, and how providers should bill for these services.

If you have any questions regarding this transmittal please contact the Division of Public and Private Provider Services by telephone at 202- 698-2000.

One Judiciary Square | 441 4th Street, NW, Suite 900S, Washington, D.C. 20001 | (202) 442-5988 | Fax (202) 442-4790

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

I. Introduction

The D.C. Telehealth Reimbursement Act of 2013 directs Medicaid to "cover and reimburse for healthcare services appropriately delivered through telehealth if the same services would be covered when delivered in person." Per the aforementioned Act, telehealth is defined as the delivery of healthcare services through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment, provided, that services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions are not included. For the purposes of coverage by the Department of Health Care Finance (DHCF), telehealth and telemedicine shall be deemed synonymous.

The purpose of providing Medicaid reimbursement for medically necessary services via telemedicine is to improve beneficiaries':

1. Access to healthcare services, with the aim of reducing preventable hospitalizations and emergency department utilization;
2. Compliance with treatment plans;
3. Health outcomes through timely disease detection and review of treatment options; and
4. Choice for care treatment in underserved areas.

Effective June 23, 2016 (for services rendered on or after that date), the District of Columbia Medical Assistance Program ("the Program") will reimburse eligible providers for eligible healthcare services rendered to Program participants via telemedicine in the District of Columbia. The Program will implement this telemedicine service for both providers and participants in the fee-for-service program. Providers must be enrolled in the Program and licensed, by the applicable Board, to practice in the jurisdiction where services are rendered. For services rendered outside of the District, providers shall meet any licensure requirements of the jurisdiction where he/she is physically located and the jurisdiction where the patient is physically located. See Appendix B for illustrative examples.

This manual contains information about the telemedicine service program, including provider and participant eligibility, covered services, and reimbursement, consistent with Section 910 of Chapter 9 (Medicaid Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

II. Telemedicine Service Model

Telemedicine is a service delivery model that delivers healthcare services through a two-way, real time interactive video-audio communication for the purpose of evaluation, diagnosis, consultation, or treatment. Eligible services can be delivered via telemedicine when the beneficiary is at the originating site,[1] while the eligible "distant" provider renders services via the audio/video connection. The Program will not reimburse for service delivery using audio-only telephones, e-mail messages, or facsimile transmissions.

III. Participant Eligibility

The program shall reimburse approved telemedicine providers only if participants meet the following criteria:

1. Participants must be enrolled in the District of Columbia Medical Assistance Program;
2. Participants must be physically present at the originating site at the time the telemedicine service is rendered[1]; and
3. Participants must provide written consent to receive telemedicine services in lieu of in-person healthcare services, consistent with all applicable District laws.

IV. Provider Site Eligibility[2]

The following providers shall be considered an originating site for service delivery via telemedicine.[3]

- Hospital
- Nursing Facility
- Federally Qualified Health Center
- Clinic
- Physician Group/Office
- Nurse Practitioner Group/Office
- DCPS
- DCPCS
- Core Service Agency[4]

---

[1] When clinically indicated, an originating site provider or its designee shall be in attendance during the patient's medical encounter with the distant site professional. An originating site provider shall not be required to be in attendance when the beneficiary prefers to be unaccompanied because the beneficiary feels the subject is sensitive. An originating site provider shall note their attendance status in the patient's medical record.

[2] All individual practitioners shall be licensed in accordance with the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 et seq. (2007 Repl. & 2012 Supp.)) or the jurisdiction where services are rendered and any implementing regulations.

[3] Providers will not receive add-on payments such as transaction fees or facility fees; to receive reimbursement; originating site providers must deliver an eligible service, distinct from the service delivered at the distant site, in order to receive reimbursement

[4] CSA providers must have the appropriate required certification from the Department of Behavioral Health

The following providers shall be considered a distant site for service delivery via telemedicine. Distant site providers may only bill for the appropriate codes outlined in Appendix A.

- Hospital
- Nursing Facility
- Federally Qualified Health Center
- Clinic
- Physician Group/Office
- Nurse Practitioner Group/Office
- DCPS
- DCPCS
- Core Service Agency[5]

V. Provider Reimbursement

D.C. Medicaid enrolled providers are eligible to deliver telemedicine services, using fee-for-service reimbursement, at the same rate as in-person consultations. All reimbursement rates for services delivered via telemedicine are consistent with the District's Medical State Plan and implementing regulations. For originating site providers, exceptions to Medicaid reimbursement are outlined in Sections VI, VII, and VIII. For distant site providers, medically necessary services that can reasonably be delivered using technology-assisted communication are specified in Appendix A.

Telemedicine providers will submit claims in the same manner the provider uses for in person services. When billing for services delivered via telemedicine, distant site providers shall enter the "GT" (via real time interactive video-audio communication) procedure modifier on the claim. Additionally, the distant site provide must report the *National Provider Identifier* (NPI) of the originating site provider in the "referring provider" portion of the claim. Services billed where telemedicine is the mode of service delivery but the claim form and/or service documentation do not indicate telemedicine (using the procedure modifiers or appropriate revenue codes and indicating the originating site provider's provider identification number) are subject to disallowances in the course of an audit.

For more information on distant site services that can reasonably be delivered via telemedicine, please see Appendix A of this guidance.

VI. Federally Qualified Health Center (FQHC) Reimbursement

In accordance with the District's Prospective Payment System (PPS) or alternative payment methodology (APM) for FQHCs, the following reimbursement parameters will be established for the purposes of telemedicine in the District:

---

[5] Providers must have the appropriate required license from the Department of Behavioral Health

- Originating Site: An FQHC provider must deliver an FQHC-eligible service in order to be reimbursed the appropriate PPS, APM, or fee-for-service (FFS) rate at the originating site;
- Distant Site: An FQHC provider must deliver an FQHC-eligible service that is listed in Appendix A in order to be reimbursed the appropriate PPS, APM, or FFS rate; and
- Originating and Distant Site: If both the originating and the distant site are FQHCs, in order for both to receive reimbursement, each site must deliver a different PPS or APM service (e.g. medical or behavioral). If both sites submit a claim for the same PPS or APM service (e.g. medical), then only the distance site will be eligible to receive reimbursement.

VII. Local Education Agency (LEA) Reimbursement

In accordance with the DCPS/DCPCS Medicaid payment methodology, the following reimbursement parameters will be established for the purposes of telemedicine in the District:

- The LEA shall only bill for distant site services listed in Appendix A that are allowable healthcare services to be delivered at DCPS/DCPCS;
- The LEA shall provide an appropriate primary support professional to attend the medical encounter with the member at the originating site. In instances where it is clinically indicated, an appropriate healthcare professional shall attend the encounter with the member at the originating site. [1]

VIII. Core Service Agency (CSA) Reimbursement

In accordance with the District's Medicaid Reimbursement Guidelines for Mental Health Rehabilitation Services (MHRS), the following reimbursement parameters will be established for the purposes of telemedicine in the District:

- In instances where the originating site is a CSA and the distance site is a CSA and the same provider identification number is used at both sites, only the distance site will be eligible for reimbursement for the CSA-eligible service listed in Appendix A.

IX. Covered Services

A description of services that may be delivered via telemedicine is included in Appendix A. The services include:

- Evaluation and management
- Consultation of an evaluation and management of a specific healthcare problem requested by an originating site provider
- Behavioral healthcare services including, but not limited to, psychiatric evaluation and treatment, psychotherapies, and counseling; and

- Speech therapy.

X. Excluded Services

The Program will not reimburse telemedicine providers for the following:

- Incomplete delivery of services via telemedicine, including technical interruptions that result in partial service delivery
- When a provider is only assisting the beneficiary with technology and not delivering a clinical service
- For a telemedicine transaction fee and/or facility fee
- For store and forward and remote patient monitoring

XI. Technical Requirements

Providers delivering healthcare services through telemedicine shall adopt and implement technology in a manner that supports the standard of care to deliver the required service. Equipment utilized for telemedicine must be of sufficient audio quality and visual clarity as to be functionally equivalent to a face-to-face encounter for professional medical services. Providers shall, at a minimum, meet the following technology requirements:

- Use a camera that has the ability to manually, or, under remote control, provide multiple views of a patient with the capability of altering the resolution, focus, and zoom requirements according to the consultation
- Use audio equipment that ensures clear communication and includes echo cancellation;
- Ensure internet bandwidth speeds sufficient to provide quality video to meet or exceed 15 frames per second;
- Use a display monitor size sufficient to support diagnostic needs used in the telemedicine service; and
- Use technology that creates video and audio transmission with less than 300 milliseconds.

XII. Medical Records

The originating and distant site providers shall maintain documentation in the same manner as during an in-person visit or consultation, using either electronic or paper medical records, which shall be retained for a period of ten (10) years or until all audits are completed, whichever is longer.

XIII. Confidentiality

A telemedicine provider shall develop a confidentiality compliance plan in accordance with guidance from the Department of Health and Human Services, Office of Civil Rights, available at: http://www.hhs.gov/sites/default/files/hipaa-simplification-201303.pdf to incorporate

appropriate administrative, physical, and technical safeguards around data encryption (both in transit and at rest) and to protect the privacy of telemedicine participants and ensure compliance with the Health Insurance, Portability, and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act of 2009.

XIV. Telemedicine Program Evaluation Survey

As a condition of participation, Medicaid providers delivering services via telemedicine will be required to respond to requests for information in the form of a telemedicine program evaluation survey from the Department of Health Care Finance. Effective 2017, DHCF shall send the survey to providers no more than once every three (3) months via email or regular US mail. A provider shall have thirty (30) calendar days to respond to the survey via email or regular US mail. The survey aims to evaluate the utilization of telemedicine services within the Medicaid fee-for-service population

XV. Definitions

Bandwidth: A measure of the amount of data that can be transmitted at once through a communication conduit.

Core Service Agency- A Department of Behavioral Health (DBH) certified community-based mental health provider that has entered into a Human Care Agreement with DBH to provide specified mental health rehabilitation services.

Data Encryption: The conversion of electronic data into another form which cannot be easily understood by anyone except authorized parties.

Distant Site: The remote setting of the eligible Medicaid provider who may furnish a healthcare service via a telecommunications system.

Echo Cancellation: A process which removes unwanted echoes from the signal on an audio and video telecommunications system.

Facility Fee: An add-on payment to a provider for the use of their facility for telemedicine.

Incomplete Service: A clinical service that is not full rendered, including but not limited to technical interruptions or other interruptions leading to the partial delivery of care.

Originating Site: The setting where an eligible Medicaid beneficiary is located at the time the healthcare service furnished via a telecommunications system occurs.

Primary Support Professional: An individual designated by the school to provide supervisory services for medically necessary services. Examples of who might fulfill this function include

paraprofessionals, classroom teachers, resource room staff, library media specialists, any other certified or classified school staff members.

Remote Patient Monitoring: A digital technology that collects medical and/or health data from individuals in one location and electronically transmits that information securely to healthcare providers in a different location for assessment and recommendations.

Store and Forward: A technology that allows for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos through secure email transmission.

Supervisory Services: The oversight of services delivered via telemedicine by a primary support professional at the originating site.

Transaction Fee: An add-on payment to a provider for delivering a service via telemedicine.

Appendix A. Eligible Distant Site Services under Telemedicine Coverage

CPT, HCPCS Billing Codes (or subsequent codes); Modifiers	Brief Service Description
GT + 90791-90792	Psychiatric diagnostic evaluation
GT + 90832-90834, 90836-90838	Individual psychotherapy
GT + 90839-90840	Psychotherapy for crisis
GT + 90845	Psychoanalysis
GT + 90846	Family psychotherapy (without patient present)
GT + 90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
GT + 90853	Group psychotherapy (other than of a multiple-family group)
GT + 92507-92508, 92521-92524	Speech therapy
GT + 96151-96155	Health and behavior assessment
GT+ 99201-99205, 99211-99215, 99221-99223, 99231-99233, 99304-99306, 99307-99310, 99281-99285 and 99288	Evaluation and management (office or other outpatient, initial and subsequent hospital care, initial and subsequent physician nursing home care, emergency room outpatient)
GT + 99241-99245 99251-99255	Consultation of an evaluation and management of a specific problem requested by originating site provider
GT + H0002	Behavioral health screening to determine eligibility for admission to treatment program
GT + H0004	Behavioral health counseling
GT + H0039	Assertive Community Treatment
GT + H2022	Community-Based Wrap Around Services
GT + T1015 SE	Clinic visit/encounter all-inclusive[6]
GT + T1023	Screening to determine the appropriateness of a consideration of an individual for participation in a specified program

[6] FQHCs must deliver an FQHC-eligible service listed in Appendix A in order to be reimbursed for this code

Appendix B. Illustrative Examples of Telemedicine Licensure Requirements

Example 1: Both Providers and Patient Physically Located in DC

	Originating Site Provider	**Distant Site Provider**
Physical Location at Time of Service	DC	DC
Licensure Requirements	Licensed in DC, by the applicable Board	Licensed in DC, by the applicable Board

Example 2: Originating Site Provider and Patient Located in DC; Distant Site Provider in MD

	Originating Site Provider	**Distant Site Provider**
Physical Location at Time of Service	DC	MD
Licensure Requirements	Licensed in DC, by the applicable Board	Licensed in MD, by the applicable Board; and Unless otherwise allowable, licensed in DC, by the applicable Board

Example 3: Originating Site Provider and Patient Located in MD; Distant Site Provider in DC

	Originating Site Provider	**Distant Site Provider**
Physical Location at Time of Service	MD	DC
Licensure Requirements	Licensed in MD, by the applicable Board	Licensed in DC, by the applicable Board; and Compliant with any applicable telemedicine-related requirements/regulations in MD

Example 4: Originating Site Provider and Patient Located in MD; Distant Site Provider in VA

	Originating Site Provider	**Distant Site Provider**
Physical Location at Time of Service	MD	VA
Licensure Requirements	Licensed in MD, by the applicable Board Compliant with any applicable telemedicine-related requirements/regulations in VA	Licensed in VA, by the applicable Board; and Compliant with any applicable telemedicine-related requirements/regulations in MD

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 (2016 Repl.)) and Section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2012 Repl.)), hereby gives notice of the adoption, on an emergency basis, of a new Section 910, entitled "Medicaid-Reimbursable Telemedicine Services," of Chapter 9 (Medicaid Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

Telemedicine services are designed to improve access to healthcare services, improve patient compliance with treatment plans, improve health outcomes through timely disease detection and treatment options; and increase capacity and choice for treatment in the District of Columbia's Medicaid program. These rules establish standards for governing eligibility for Medicaid beneficiaries receiving health services via telemedicine under the Medicaid fee-for-service program, and to establish conditions of participation and reimbursement policies for providers who deliver healthcare services to Medicaid beneficiaries via telemedicine.

In accordance with the Telehealth Reimbursement Act of 2013, effective October 17, 2013 (D.C. Law 20-26; D.C. Official Code § 31-3861 (2013 Repl.)), Medicaid will cover and reimburse healthcare services appropriately delivered through telemedicine if the same services would be covered when delivered in person. These rules establish: (1) eligibility criteria for the receipt of telemedicine services; and (2) conditions of participation for providers who deliver telemedicine services as part of the District of Columbia's Medicaid program.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of beneficiaries who face barriers to accessing Medicaid services. Beneficiaries may be unable to access traditional in-person Medicaid services because they face unique health challenges that make travelling to receive healthcare services difficult, or because a specialty provider is not located in their community or healthcare services area. Telemedicine provides a new service delivery pathway to enable these beneficiaries to receive ongoing Medicaid services via telecommunications. These services will be essential to ensure that beneficiaries will have continued access to health care. Therefore, to ensure that the beneficiary's health, safety and welfare are not threatened by the lapse in access to ongoing healthcare services provided by qualified providers, 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 July 8, 2016 at 63 DCR 009435. The comment period officially closed on August 8, 2016. Comments were received from the D.C. Department of Behavioral Health (DBH), American Speech-Language Hearing Association (ASHA), Children's Law Center (CLC), and Unity Health Care (UHC). DHCF carefully considered as comments received, as detailed below.

The following comments were received regarding expansion of Provider Site eligibility:

DBH requested expansion of Provider Site eligibility to those sites affiliated with the Home and Community Based Services (HCBS) Medicaid Waiver program. DBH stated that its behavioral health clinics treat one hundred and ninety-one (191) individuals with intellectual and developmental disabilities, ninety-seven percent (97%) of which receive HCBS Medicaid Waiver services. Many of these individuals also have chronic physical conditions, necessitating one to one (1:1)staffing and twenty-four/seven (24/7) supervision in the community in order to ensure their safety and the safety of others. DBH stated that it is very challenging for such patients to successfully complete their psychiatric and medical appointment in the traditional face-to-face clinic setting. Some of the obstacles that are routinely encountered for a typical doctor's visit include: lack of transportation; unreliable transportation; and significant patient agitation during transport and at the clinic itself. DBH believes that extending telemedicine into locations affiliated with HCBS Waiver providers and/or within the patient's own home would significantly improve access to care for this vulnerable population by minimizing travel and wait times. Patients would be more likely to attend their appointments if given the option of receiving care in a more convenient and familiar environment closer to their home. Family members, caretakers, and guardians could be more involved in medical decisions and treatment planning, and it would help facilitate coordination of care between 35 K Street, the HCBS Waiver service providers, and the DC Department of Disability Services to prevent mental health crises, emergency room visits and hospitalization. Most importantly, it supports our ultimate goal of allowing individuals to live in their own homes and communities rather than in institutional setting.

Based on the language of the current rule, there is no need for revision to address DBH's concern. Eligible providers include the following provider types: Hospital; Nursing Facility; Federally Qualified Health Center (FQHC); Clinic; Physician Group/Office; Nurse Practitioner Group/Office; DC Public School (DCPS); DC Public Charter School (DCPCS); and Core Service Agency (CSA). A clinic enrolled as a Medicaid provider would satisfy the criteria and be eligible to participate. For example, DBH's facility at 35 K Street is enrolled a Mental Health Clinic and, thus, would be an eligible provider under the Clinic category.

DBH and UHC requested that DHCF consider one additional "originating site" – a beneficiary's home. For Behavioral Health and Focused Home Health, UHC believes that "home-based" telemedicine will prove to be an invaluable tool for case management and care coordination. UHC further stated that telemedicine offers an efficient and convenient alternative to face-to-face behavioral health services for some customers. UHC urged DHCF to expand the list of eligible "originating sites" to include a beneficiary's home for the purpose of receiving behavioral health services. If used properly, UHC stated that home-based telemedicine can reduce unnecessary emergency room usage, hospital admissions, and readmissions. Just as with behavioral health services, UHC encouraged DHCF to permit a beneficiary's home to serve as an "originating site" for certain services.

Upon careful consideration, DHCF has concluded that the home will not be included as an originating site in this rule for the reasons that follow. First, the Centers for Medicare and Medicaid Services (see https://www.medicaid.gov/medicaid-chip-program-information/by-

2

topics/delivery-systems/telemedicine.html) indicates that States that implement telemedicine without a State Plan Amendment (SPA) must "reimburse for telemedicine services the same way/amount that they pay for face-to-face services/visits/consultations." DHCF is not using a SPA to implement telemedicine reimbursement and our fee schedule does not currently include coverage at home for any of the allowable telemedicine services.

Second, the current hub and spoke model makes it difficult to include the home as an originating site. As part of this structure, DHCF is requiring a provider to be in attendance at the originating site (when clinically indicated). Adding the home as an originating site is inconsistent with this requirement. It also adds new operational and financial considerations. There would be no utilization management controls in place, potentially allowing a beneficiary to misuse this modality. Additionally, there may be HIPAA concerns with this approach. DHCF recognizes stakeholders' desire to utilize the home as an originating site. DHCF is committed to evaluating this initial iteration of telemedicine and exploring future iterations of telemedicine, either through updates to the rules, a SPA, or alternative payment models that support telemedicine (with or without direct reimbursement for telemedicine).

The following comments were received regarding the reimbursement of rehabilitative services:

ASHA requested that DHCF include reimbursement for audiology services in § 910.11,. Upon careful consideration, the only rehabilitative service rendered through the telemedicine service delivery model that DHCF will reimburse is speech-therapy. Other rehabilitative services, like audiology, present higher standards of care that, at this time, cannot be ensured. Examples of such include the absence of policies and procedures, a plan for the presence of on-site technicians trained in the installation and use of various audiology equipment, credentialing of on-site facilities, and a method for reimbursement of both sites. Accordingly, DHCF will amend § 910.11(d) to state "speech therapy" only.

The following comments were received regarding compliance with the consent requirements of Section 3026 of Title 5-E of the District of Columbia Municipal Regulations:

CLC requested clarification as to whether § 910.6 is intended to cover all "consent requirements" for the District of Columbia Charter Schools, or whether it only applies to consent regarding the evaluation or reevaluation of children with disabilities. The Medicaid reimbursable school-based health services are currently exclusively for children with disabilities. DHCF is exploring options to expand the availability of Medicaid-reimbursed health services to all Medicaid-eligible children and accordingly amended Section 910.6 to read: "Comply with any applicable consent requirements under District laws, including but not limited to Section 3026 of Title 5-E of the District of Columbia Municipal Regulations" in order to afford flexibility in the application of additional consent requirements based on future policy developments.

The following comments were received regarding consent of youth receiving mental health services or mental health supports:

UHC requested that DHCF clarify § 910.5 to expressly include language regarding consent protections for youth. DHCF agrees with this comment and will amend § 910.5 to read:

"Provide written consent to receive telemedicine service in lieu of face-to-face healthcare service, consistent with all applicable District laws."

The following comments were received regarding the word "accompany" in § 910.17:

CLC requested that DHCF clarify whether the term "accompany" used in § 910.17 means that the "primary support professional" is responsible for escorting the patient, or will be required be present in the room while the patient is receiving services. DHCF agrees that the proposed language was ambiguous about intent of the role and requirements for the primary support professional. DHCF is recommending amendments to clarify intention that primary support professionals be present except in circumstances where it is not clinically appropriate or when the beneficiary feels the subject is sensitive. To address this, DHCF recommends amending Section 910.17 to read: "When DCPS or DCPCS is the originating site provider, a primary support professional shall be in attendance during the patient's medical encounter, except in instances referenced in Subsection 910.16."

The following comments were received regarding clarification of the term "supervisory services" in § 910.18:

CLC stated that the term "supervisory services" used in § 910.18 is unclear in its meaning and should be better defined. As "primary support professional" is defined, CLC has concerns regarding the privacy and the confidentiality of the patient while having such a person in the room with the patient, especially with regard to children receiving telehealth behavioral/mental health services. The American Academy of Child & Adolescent Psychiatry recommends that providers should spend some time interviewing the youth alone. DHCF agrees that the proposed language was ambiguous about the term supervisory services. DHCF is recommending a definition to clarify the term. To address this, DHCF recommends amending Section 910.99 to read: "Supervisory Services – The oversight of services delivered via telemedicine by a primary support professional at the originating site." Privacy concerns are addressed in Sections 910.16 and 910.17.

While not explicitly requested in this comment, DHCF did hear from stakeholders that they are uncomfortable with the requirement that the originating site provider or designee is present with the patient. To address this concern, DHCF will clarify that presence in the room is only appropriate when clinically indicated but not when the beneficiary feels the subject is sensitive. This would address concerns about situations where it is more appropriate for the patient to have direct, one-on-one interaction without the presence of the additional provider. To address this, DHCF will amend § 910.16 to read: "When clinically indicated, an originating site provider or its designee shall be in attendance during the patient's medical encounter with the distant site professional. An originating site provider shall not be required to be in attendance when the beneficiary prefers to be unaccompanied because the beneficiary feels the subject is sensitive. Sensitive topics may include counselling related to abuse, or other psychiatric matters. An originating site provider shall note their attendance in the patient's medical record."

The following comments were received regarding payment of a facility fee by DHCF:

UHC stated that, as proposed, the rule does not permit telemedicine providers to receive a transaction or facility fee associated with providing telemedicine services to their Medicaid beneficiaries and that without these fees, providers will find it nearly impossible to invest in the technology and infrastructure to support telemedicine. Unity asked that DHCF reconsider this prohibition and establish a transaction and/or facility fee for telemedicine service. DHCF is unable to agree to this change due to limited authority to provide the requested fee. Since telemedicine is being implemented without a SPA, DHCF can only offer add-on payments that are consistent with the current fee schedule. Currently, the only eligible providers that can receive a facility fee under our current fee schedule would be hospitals and no other providers are eligible to receive a transaction fee. As such, DHCF is unable to include a transaction and/or facility fee for all providers and has decided not to allow one.

However, the proposed rule providing a new FQHC payment methodology increases payment rates for FQHCs that adopt the alternative payment methodology rate. FQHCs that adopt the new Alternative Payment Methodology (APM) will be able to include in allowable costs the IT costs associated with patient care, which may include telemedicine implementation and maintenance costs. Thus, FQHCs like Unity will be able to include these costs as the basis of their new APM rate when the rates are rebased based on actual costs in future years.

The following comments were received regarding reimbursement of store-and-forward telemedicine services in the areas of dermatology, radiology, and ophthalmology, and remote patient monitoring reimbursement:

UHC stated that, as proposed, the rule excludes providers from obtaining reimbursement for all store-and-forward telemedicine services and encouraged DHCF to reconsider this across-the-board prohibition. At present, nine states permit reimbursement for certain categories of store-and-forward telemedicine services in the Medicaid programs. United stated that given the insufficient number of specialist in underserved communities and the transportation barriers that many FFS beneficiaries face, DHCF should permit reimbursement for store-and-forward telemedicine services in the following areas: dermatology, radiology and ophthalmology.

As with store-and –forward telemedicine, the rule also prohibits all reimbursements for remote patient monitoring (RPM). At present, sixteen (16) states permit some form of reimbursement for RPM in their Medicaid programs, especially for those individuals who suffer from chronic conditions and are at risk for hospitalization. UHC requested that DHCF reevaluate this blanket prohibition and instead permit RPM subject to the following conditions: (1) Require that RPM services be ordered by a physician, physician assistant, or nurse practitioner; (2) Establish "limiting" criteria for who is eligible to receive RPM services, e.g. individuals who: (a) have been diagnosed with one or more of the following chronic conditions: diabetes, congestive heart failure, asthma, or chronic obstructive pulmonary disease; (b) have two (2) or more hospitalization and /or emergency room visits in the past twelve (12) months times for one of the chronic conditions listed above (with two (2) or more separate hospitalizations and/or emergency room visits for the same chronic condition); or (c) are capable of using RPM equipment and transmitting the necessary data or have someone who can assist with the transmission of the data; (3) Limit the daily rate for reimbursement regardless of the number of chronic conditions being monitored; (4) Terminate RPM if the beneficiary or caregiver misses more than five monitoring

events in a 30 day period; and (5) Require prior authorization by District Medicaid of RPM services for an eligible beneficiary.

Given the Department's principal objectives of reducing unnecessary emergency room utilization, decreasing avoidable hospitalizations, and lowering the number of hospital readmissions within thirty (30) days of a previous discharge, Unity submitted that the Department would be well served by embracing, and reimbursing for RPM services.

DHCF is unable to include the requested reimbursement due to restrictions under District and federal law. The Telehealth Reimbursement Act of 2013, effective October 17, 2013 (D.C. Law 20-26; D.C. Official Code § 31-3861 (2013 Repl.)), indicates that telemedicine services shall be delivered "through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment; provided, that services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions are not included." Additionally, the Centers for Medicare and Medicaid Services (see https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/telemedicine.html) indicate that States that implement telemedicine without a SPA must "reimburse for telemedicine services the same way/amount that they pay for face-to-face services/visits/consultations." DHCF is not using a SPA to implement telemedicine reimbursement and our fee schedule does not currently include coverage of store and forward or remote patient monitoring applications.

Lastly, DHCF recommends aligning the language in §§ 910.24 and 910.25 to reflect that FQHCs may be reimbursed at the applicable prospective payment system (PPS), or alternative payment methodologies (APM) rate. To address this, DHCF recommends amending § 910.25 to read: "If an FQHC is both the originating and distant site provider, and both sites deliver the same healthcare service as outlined in Subsection 910.24, only the distant site will be eligible for reimbursement."

DHCF also recommends amending § 910.5(c) to clarify that the term "face-to-face" refers to telemedicine consults and the term "in-person" only includes consults delivered while both patient and provider are physically present. Therefore, Subsection 910.5(c) has been amended to read: "Provide written consent to receive telemedicine services in lieu of in-person healthcare services."

In sum, the following changes have been made to address commenters' concerns for these second emergency and proposed rules: (1) changing the term "face-to-face" to "in-person" to conform to other DHCF rulemakings; (2) clarifying that consent for the delivery of telemedicine services must be obtained in accordance with all applicable District laws; (3) specifying that rehabilitation services offered through telemedicine are limited to speech therapy; (4) clarifying that the originating site provider is only required to be present during delivery of the distant site service when clinically indicated; (5) changing the term "accompany" to "be in attendance" in § 910.17 to clarify the responsibilities of the primary support professional; (6) including the term "alternative payment methodology" in § 910.24 to conform to other DHCF rulemakings; and (7) adding a definition for "supervisory services."

The emergency rulemaking was adopted on April 27, 2017 and became effective immediately. The emergency rules will remain in effect for one hundred and twenty (120) days or until August 25, 2017, unless superseded by publication of a Notice of Final Rulemaking in the *DC. Register.*

The Director of DHCF also gives notice of the intent to take final rulemaking action to adopt these rules in not less than thirty (30) days after the date of publication of this notice in the *D.C. Register*.

Chapter 9, MEDICAID PROGRAM, of Title 29 DCMR, PUBLIC WELFARE, is amended as follows:

A new Section 910, MEDICAID-REIMBURSABLE TELEMEDICINE SERVICES, is added to read as follows:

910 MEDICAID-REIMBURSABLE TELEMEDICINE SERVICES

910.1 The purpose of this section is to establish the Department of Health Care Finance (DHCF) standards governing eligibility for Medicaid beneficiaries receiving healthcare services via telemedicine under the Medicaid fee-for-service program, and to establish conditions of participation for providers who deliver healthcare services to Medicaid beneficiaries via telemedicine.

910.2 Telemedicine is a service delivery model that delivers healthcare services as set forth in Subsections 910.10 and 910.11 through a two-way, real time interactive video-audio communication for the purpose of evaluation, diagnosis, consultation, or treatment.

910.3 The originating site shall be the place where an eligible Medicaid beneficiary is located at the time the healthcare services furnished for payment via a telecommunications system occurs.

910.4 The distant site shall be the place where the eligible Medicaid provider who furnishes and receives payment for the covered service(s) via a telecommunication system,

910.5 To be eligible for Medicaid reimbursement of telemedicine services under these rules, a Medicaid beneficiary shall meet the following criteria:

(a) Be enrolled in the District of Columbia Medicaid program pursuant to Chapter 95 of Title 29 of the District of Columbia Municipal Regulations;

(b) Be physically present at the originating site at the time the telemedicine service is rendered; and

(c) Provide written consent to receive telemedicine services in lieu of in-person healthcare services, consistent with all applicable District laws.

910.6 A telemedicine provider shall meet the following program requirements:

(a) Be enrolled as a Medicaid Provider and comply with all the requirements set forth under Chapter 94 (Medicaid Provider and Supplier Screening, Enrollment, and Termination) of Title 29 DCMR including having a completed, signed, Medicaid Provider Agreement;

(b) Comply with all technical, programmatic and reporting requirements as set forth in this section;

(c) Be licensed in the jurisdiction where the provider is physically located; and

(d) Comply with any applicable consent requirements under District laws, including but not limited to Section 3026 of Title 5-E of the District of Columbia Municipal Regulations if providing telemedicine services at the District of Columbia Public School (DCPS) or District of Columbia Public Charter Schools (DCPCS).

910.7 An originating site provider shall consist of the following provider types:

(a) Hospital;

(b) Nursing Facility;

(c) Federally Qualified Health Center (FQHC);

(d) Clinic;

(e) Physician Group/Office;

(f) Nurse Practitioner Group/Office;

(g) DCPS;

(h) DCPCS; and

(i) Core Service Agency (CSA).

910.8 A distant site provider shall consist of the following provider types:

(a) Hospital;

(b) Nursing Facility;

(c) FQHC;

(d) Clinic;

(e) Physician Group/office;

(f) Nurse Practitioner Group/Office;

(g) DCPS;

(h) DCPCS; and

(i) CSA

910.9 When the provider and patient receiving healthcare services are located in the District of Columbia, all individual practitioners shall be licensed in accordance with the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2012 Repl. & 2016 Supp.)). For healthcare services rendered outside of the District, the provider of the services shall meet any licensure requirements of the jurisdiction in which the provider is physically located and where the patient is physically located.

910.10 Medicaid reimbursement of healthcare services rendered at the originating site shall include only those healthcare services which are covered under the Medicaid State Plan and implementing regulations.

910.11 Medicaid reimbursement of healthcare services rendered at the distant site shall include only the following healthcare services:

(a) Evaluation and management;

(b) Consultation of an evaluation and management of a specific healthcare problem requested by an originating site provider;

(c) Behavioral healthcare services including, but not limited to, psychiatric evaluation and treatment, psychotherapies, and counseling; and

(d) Speech therapy.

910.12 To be eligible for Medicaid reimbursement, a telemedicine provider shall utilize the reimbursement codes designated for telemedicine and available at www.dhcf.dc.gov.

910.13 A telemedicine provider shall comply with the following technology requirements:

(a) Use a camera that has the ability to, either manually or by remote control, provide multiple views of a patient and has the capability of altering the camera's resolution, and focus as needed during the consultation;

(b) Use audio equipment that ensures clear communication and includes echo cancellation;

(c) Ensure internet bandwidth speeds sufficient to provide quality video to meet or exceed fifteen (15) frames per second;

(d) Use a display monitor size sufficient to support diagnostic needs used in the telemedicine services; and

(e) Use video and audio transmission equipment with less than a three hundred (300) millisecond delay.

910.14 Effective January 1, 2017, DHCF shall send a Telemedicine Program Evaluation survey to providers, no more than every three (3) months, via email or regular US mail. A provider shall have thirty (30) calendar days to respond to the survey via email or regular US mail.

910.15 A telemedicine provider shall develop a confidentiality compliance plan in accordance with Health Insurance, Portability, and Accountability Act of 1996, approved August 21, 1996 (Pub. L. No. 104-191, 110 Stat. 1936) (HIPAA) administrative simplification guidance from the Department of Health and Human Services, Office of Civil Rights, available at: http://www.hhs.gov/sites/default/files/hipaa-simplification-201303.pdf to incorporate appropriate administrative, physical, and technical safeguards around data encryption (both for data in transit and at rest) and to protect the privacy of telemedicine participants and ensure compliance with the HIPAA and the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, approved February 17, 2009 (Pub. L. No. 111-5, §§ 13001-424, 123 Stat. 226).

910.16 When clinically indicated, an originating site provider or its designee shall be in attendance during the patient's medical encounter with the distant site professional. An originating site provider shall not be required to be in attendance when the beneficiary prefers to be unaccompanied because the beneficiary feels the subject is sensitive. Sensitive topics may include counselling related to abuse, or other psychiatric matters. An originating site provider shall note their attendance status in the patient's medical record.

910.17 When DCPS or DCPCS is the originating site provider, a primary support professional shall be in attendance during the patient's medical encounter, consistent with Subsection 910.16.

910.18 A primary support professional is an individual designated by the school to provide supervisory services for school-based healthcare services. A primary support professional includes a paraprofessional, classroom teacher, resource room staff, library media specialist, and any other certified or classified school staff member.

910.19 Each telemedicine provider shall maintain complete and accurate beneficiary records of services provided (not to include videos) for each beneficiary that document the specific healthcare services provided to each beneficiary for a period of ten (10) years or until all audits are completed, whichever is longer.

910.20 All beneficiary, personnel and telemedicine program administrative and fiscal records shall be maintained so that they are accessible and readily retrievable, upon request, for inspection and review or audit by DHCF, the federal Centers for Medicare and Medicaid Services, and other authorized government officials or their agents.

910.21 A provider shall not be reimbursed by Medicaid for healthcare services delivered via telemedicine when:

(a) A provider is only assisting the beneficiary with technology and not delivering a healthcare service; or

(b) The healthcare service is incomplete.

910.22 Reimbursement shall be prohibited for an incomplete healthcare service when the service is not fully rendered due to technical interruptions or other service interruptions resulting in the partial delivery of care.

910.23 Telemedicine providers shall be subject to the standard billing practices that are in place for the healthcare services provided in accordance with the relevant regulations, policies, or transmittals issued by the DHCF.

910.24 Where a FQHC provides any of the allowable healthcare services described within this Section at the originating or distant site, the FQHC shall be reimbursed at the applicable rate, prospective payment system (PPS), alternative payment methodology (APM), or fee-for-service rate, consistent with Chapter 45 (Medicaid Reimbursement for Federally Qualified Health Centers) of Title 29 DCMR and Subsection 910.27.

910.25 If an FQHC is both the originating and distant site provider, and both sites deliver the same healthcare service as outlined in Subsection 910.24, only the distant site will be eligible for reimbursement.

910.26 In accordance with the DCPS/DCPCS Medicaid payment methodology, when DCPS or DCPCS provides any of the allowable healthcare services at the

originating or distant site, the provider shall only be reimbursed for distant site healthcare services that are Medicaid eligible and are to be delivered in a licensed education agency.

910.27 In accordance with the Mental Health Rehabilitation Services Medicaid payment regulations under Chapter 54 of Title 29 DCMR, and consistent with Chapter 34 of Title 22-A DCMR, when an originating site and a distant site are CSAs, and the same provider identification number is used for a serviced delivered via telemedicine, only the distant site provider shall be eligible for reimbursement of the allowable healthcare services described within this section.

910.28 Telemedicine providers shall not be reimbursed for a telemedicine transaction fee and/or facility fee.

910.29 Telemedicine providers shall not be reimbursed for store and forward and remote patient monitoring.

910.99 DEFINITIONS

When used in this section, the following terms and phrases shall have the meanings ascribed below:

Bandwidth - A measure of the amount of data that can be transmitted at one time through a communication conduit

Core Service Agency - A Department of Behavioral Health (DBH) certified community-based mental health provider that has entered into a Human Care Agreement with DBH to provide specified mental health rehabilitation services.

Data Encryption - The conversion of electronic data into another form which cannot be easily understood by anyone except authorized parties.

Echo Cancellation - A process which removes unwanted echoes from the signal on an audio and video telecommunications system.

Facility Fee - An add-on payment to a provider for the use of their facility for telemedicine.

Fee-For-Service Program - A healthcare payment system that provides Medicaid reimbursement to providers in accordance with a fee schedule, rather than through a Managed Care Organization.

Incomplete Service - A healthcare service that is not fully rendered for reasons to include any technical interruptions or other service interruptions that result in the partial delivery of care.

Medical Encounter - A healthcare service delivered through a through a two-way, real time, interactive video-audio communication system.

Remote Patient Monitoring - A digital technology that collects medical and/or health data from individuals in one location and electronically transmits that information securely to health care providers in a different location for assessment and recommendations.

Store and Forward - A technology that allows for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos through secure email transmission.

Supervisory Services – The oversight of services delivered via telemedicine by a primary support professional at the originating site.

Transaction Fee - An add-on payment to a provider for delivering a healthcare service via telemedicine.

Comments on these rules should be submitted in writing to Claudia Schlosberg, J.D., Medicaid Director, Department of Health Care Finance, Government of the District of Columbia, 441 4th Street, N.W., Suite 900, Washington, D.C. 20001, via telephone on (202) 442-8742, via email at DHCFPubliccomments@dc.gov, or online at www.dcregs.dc.gov, within thirty (30) days of the date of publication of this notice in the *D.C. Register*. Additional copies of these rules are available from the above address.