DEPARTMENT OF BEHAVIORAL HEALTH

NOTICE OF FINAL RULEMAKING

The Interim Director of the Department of Behavioral Health (the "Department"), pursuant to the authority set forth in Sections 5113, 5115, 5117 and 5118 of the Department of Behavioral Health Establishment Act of 2013, effective December 24, 2013 (D.C. Law 20-61; D.C. Official Code §§ 7-1141.02, 7-1141-04, 7-1141.06 and 7-1141.07 (2012 Repl.)), hereby gives notice of the adoption of amendments to Chapter 25, entitled "Health Home Certification Standards", of Subtitle A (Mental Health) of Title 22 (Health) of the District of Columbia Municipal Regulations ("DCMR").

This Final Rulemaking aligns the Health Home regulations to the revised State Plan Amendment ("SPA") approved by the Centers for Medicare and Medicaid Services on February 21, 2019. The three main revisions include establishing the requirements and process for certifying a Freestanding Mental Health Clinic ("FSMHC") as a Health Home provider; removing community support from the ineligible services so it can be billed as a separate service; and making the edits to Health Home service definitions to reflect programmatic changes and changes to the SPA.

A Notice of Emergency and Proposed Rulemaking was published on January 11, 2019 at 66 DCR 000495. DBH did not receive any comments and no changes were made to the emergency and proposed rulemaking. This rule was adopted as final on March 19, 2019 and will be effective on the publication of this notice in the *D.C. Register*.

Chapter 25, HEALTH HOME CERTIFICATION STANDARDS, of Title 22-A DCMR, MENTAL HEALTH, is amended as follows:

The following subsections in Section 2500, HEALTH HOME PROGRAM, are amended to read as follows:

2500.1 These rules establish the requirements and process for certifying a Mental Health Rehabilitation Services (MHRS) Core Services Agency (CSA) or a Freestanding Mental Health Clinic (FSMHC) as a Health Home provider in the District of Columbia.

2500.2 A Health Home is an MHRS CSA or FSMHC that serves as the coordinating entity for services offered to a person with a serious and persistent mental illness (consumer) who has or is at risk of developing co-occurring chronic medical conditions. The provider is the central point for coordinating patient-centered and population-focused care for both behavioral health and other medical services. The Health Home provider is compensated on a per member per month (PMPM) basis to coordinate care between itself as the behavioral health provider, and other physical and specialty health care providers and community-based services and supports. The purpose and goal of individualized care coordination is to increase collaboration and integration of behavioral, health and community based services,

improve management of chronic conditions, and reduce avoidable health care costs, specifically for hospital admissions, readmissions and emergency room visits.

The following subsections in Section 2501, CERTIFICATION REQUIREMENTS, are amended to read as follows:

2501.2 The following minimum eligibility requirements shall apply to any FSMHC or CSA seeking certification as a Health Home:

(a) Current certification as an MHRS CSA in accordance with Chapter 34 of this subtitle or FSMHC in accordance with Chapter 8 of Title 29 (Public Welfare) of the D.C. Municipal Regulations;

(b) Current enrollment as a D.C. Medicaid provider for the delivery of MHRS or FSMHC services;

(c) Use of the Department of Behavioral Health's (the Department's), data management system for all Health Home-related services and functions;

(d) No current or pending exclusions, suspensions or debarment from any federal or D.C. healthcare program; and

(e) Demonstrated ability through readiness assessments and training to comply with the terms and requirements of this chapter.

2501.3 A FSMHC or MHRS CSA seeking certification shall submit an application in a format established by the Department.

…

2501.6 The Department's certification shall specify the number of Health Home teams certified at each provider. A Health Home team can serve up to three hundred (300) individuals and consists of the following required staff: Health Home Director, Primary Care Liaison, and Nurse Care Manager(s). No provider shall add additional Health Home teams unless the addition is approved by the Department.

Section 2504, HEALTH HOME SERVICES ELIGIBILITY, is amended to read as follows:

2504.1 To be eligible for Health Home services, a consumer shall:

(a) Be eligible for Medicaid;

(b) Be diagnosed as having a serious and persistent mental illness;

(c) Be enrolled in a CSA or FSMHC; and

(d) Consent to be enrolled in a Health Home and authorize the disclosure of his or her mental health, physical health and other relevant information for the purpose of integrating primary and behavioral health care and services.

2504.2 Consumers may only be enrolled with one (1) Health Home at a time and may opt-out at any time. Providers shall document in writing and in forms prescribed by the Department a consumer's informed consent to opt-in or opt-out of the Health Home program.

2504.3 The following categories of beneficiaries shall not be eligible for the Health Home program under this chapter:

(a) Consumers currently enrolled in Assertive Community Treatment (ACT) as described in Chapter 34;

(b) Consumers 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 District of Columbia Municipal Regulations (DCMR);

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

(d) Consumers residing in a nursing facility;

(e) Consumers residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities; and

(f) Consumers enrolled in the *My Health GPS* program, as described in Chapter 102 of Title 29 DCMR. A consumer who is eligible for both this Health Home and the My *Health GPS* Program may choose to enroll in either program but not both.

Section 2506, COMPREHENSIVE CARE MANAGEMENT, is amended as follows:

2506.1 One of the goals of the Health Home Program is to maintain and/or improve the health of their population through the delivery of appropriate services. Comprehensive Care Management requires Health Home teams to gather demographic and health data about their consumers and tailor interventions and evidence based practices to meet the specific needs of their population. This population management approach requires the following:

(a) Construction of standardized, evidence-based protocols and clinical pathways for mental health, physical health, social, employment, and economic needs;

(b) Tracking and monitoring of the consumer's health, social and employment status based on the protocols and pathways;

(c) Development and dissemination of reports on satisfaction, health status, cost and quality to guide Health Home service delivery and design;

(d) Development of partnerships with physical health care providers and community-based entities in order to facilitate the sharing of information and timely responses to each consumer's needs; and

(e) Health Homes will use aggregated data to determine levels of consumer engagement, progress toward goals, and adherence to or variance from treatment guidelines. Based on this analysis, Health Homes will prioritize outreach, reminders and notifications to individuals and/or providers. Health Homes will systematically review and report quality metrics, assessment results, and service utilization in order to evaluate health status, service delivery, and consumer satisfaction.

2506.2 Comprehensive Care Management is the assessment and identification of health risks leading to the development and implementation of a care plan that addresses health risks and the individualized needs of the whole person. Care plan development will be led by qualified practitioners operating within their scope of practice with input from members of the Health Home team and external resources. Activities include but are not limited to the following:

(a) Monitoring of the consumer and population health status and service use;

(b) Conduct an assessment of health risks and identification of high risk sub groups;

(c) Collect behavioral, primary, acute and long-term care information from health and social service providers, including but not limited to MHRS Diagnostic Assessments and individual recovery or treatment plans, physical assessments from PCPs, and hospital discharge planners to facilitate the creation of a person-centered care plan for every enrolled individual, that is updated at set intervals (as detailed in the DCMR) and following an unplanned inpatient stay;

(d) Reassessment of health assessment(s) annually or more frequently as required by the consumer's health;

(e) Identification of service needs of consumers and construction of a person-centered comprehensive care plan addressing physical and behavioral health chronic conditions, current health status, and goals for improvement; and

(f) Review and updates persons-centered care plan every one hundred eighty (180) days and as needed.

Section 2507, CARE COORDINATION, is amended as follows:

2507.1 Care Coordination is the facilitation or implementation of the comprehensive care plan through appropriate linkages, referrals, coordination and follow-up to needed services and support. Care Coordination provides assistance with the identification of individual strengths, resources, preferences and choices. Care Coordination is a function shared by the entire Health Home Team and may involve, but is not limited to, the facilitation or implementation of the following:

(a) Developing strategies and supportive mental health intervention for avoiding out-of-home placement and building stronger family support skills and knowledge of the consumer's strengths and limitations;

(b) Providing telephonic and other electronic reminders of appointments;

(c) Providing telephonic consults and outreach;

(d) Communicating with family members;

(e) Identifying outstanding items on patient visit summaries such as referrals, immunization, self-management goal support and health education needs;

(f) Assisting with medication reconciliation;

(g) Making appointments;

(h) Providing patient education materials;

(i) Assisting with arrangements such as transportation, directions and completion of durable medical equipment requests;

(j) Obtaining missing records and consultation reports;

(k) Participating in hospital and emergency room (ER) transition care;

(l) Coordination with other health care providers to ensure screenings follow-up is completed;

(m) Coordinating with Fire and Emergency Medical Services to promote appropriate utilization of emergency medical and transport services; and

(n) Ensure that consumers continue connections to and maintain eligibility for any public benefit to which the beneficiary may be entitled, including Medicaid.

Section 2508, COMPREHENSIVE TRANSITIONAL CARE, is amended as follows:

2508.1 Comprehensive Transitional Care includes the Health Home's efforts to reduce hospital emergency department and inpatient admissions, readmissions and length of stay through planned and coordinated transitions between health care providers locations, settings and levels of care. Health Homes will increase individual's and family members' ability to manage care and live safely in the community, shifting the use of reactive or emergency care and treatment to proactive health promotion and self-management. Comprehensive Transitional Care includes, but is not limited to:

(a) Contact with the consumer within forty-eight (48) hours of the completed transition from inpatient settings and ER visits;

(b) Outreach to consumers to ensure appropriate follow-up after transitions;

(c) Ensuring visits for consumers with the appropriate health and community-based service providers following the completed transition;

(d) Developing strategies and supportive health interventions that reduce the risk for or prevent out-of-home placements for adults and builds stronger family support skills and knowledge of the adult's strengths and limitations;

(e) Developing chronic health prevention and illness management strategies and plans;

(f) Reviewing the discharge summary and instructions;

(g) Ensuring that medication reconciliation has been completed;

(h) Ensuring that follow-up appointments and tests are scheduled and coordinated;

(i) Assessing the patient's risk status for readmission or other failure to obtain appropriate community-based care;

(j) Arranging for follow-up care, if indicated in the discharge plan;

(k) Planning for appropriate clinical care post-discharge, including home health services or other necessary skilled care;

(l) Planning for appropriate housing support services post-discharge, including facilitating linkages to temporary or permanent housing;

(m) Arranging transportation for transitional care and follow-up appointments as needed;

(n) Scheduling appointments for the beneficiary with a primary care provider or appropriate specialist(s) within one (1) week of discharge; and

(o) Opting out of the Health Home Program.

Section 2509, HEALTH PROMOTION, is amended as follows:

2509.1 Health Promotion service involves the provision and facilitation of health education to the individual (family member and or significant other) specific to his/her chronic illness. The service may also involve the use of data to identify and prioritize particular areas of need within the patient population; research best-practice interventions; coordinate or refer individuals to appropriate health promotion activities in group and individual settings; evaluate the effectiveness of the interventions, and plan accordingly. Health promotion also involves ensuring the connection of the individual to peer/recovery supports including self-help/self-management and advocacy groups, to support for improving an individual's social network, and to educational opportunities for the individual about accessing care in appropriate settings. This service may include but is not limited to:

(a) Providing consumer education and development of self-monitoring and health management related to consumers' particular chronic conditions as well as in connection with healthy lifestyle and wellness; nutrition counseling, substance abuse prevention, smoking prevention and cessation and physical activity;

(b) Assisting with medication reconciliation;

(c) Developing and implementing health promotion campaigns;

(d) Connecting consumers with peer and recovery supports including self-help and self-management and advocacy groups;

(e) Educating the consumer about accessing care in appropriate settings, including appropriate utilization of 911 services;

(f) Assessing the consumer's understanding of their health conditions and motivation to engage in self- management; and

(g) Using coaching and evidence-based practices such as motivational interviewing to enhance the beneficiary's understanding of his or her health conditions and motivation to achieve health and social goals.

Subsection 2510.2 of Section 2510, INDIVIDUAL AND FAMILY SUPPORT SERVICES, is amended as follows:

2510.2 Individual and Family Support Services include:

(a) Activities that facilitate the continuity in relationships between consumer/family and physician and care manager;

(b) Advocacy on a consumers' behalf to identify and obtain needed resources such as medical transportation and other benefits for which they may be eligible;

(c) Consumer education on how to self-manage their chronic condition (s);

(d) Providing opportunities for the families to participate in consumers' assessment and care treatment plan developments;

(e) Efforts that ensure that Health Home services are delivered in a manner that is culturally and linguistically competent;

(f) Efforts that promote personal independence and empower the consumers to improve their own environment and health. This may include engagement with consumers' families in identifying solutions to improve consumers' health and environment and helping consumers and their families with consumer's authorizations to access the consumers' health record information or other clinical information;

(g) Language interpretation services;

(h) Housing assistance services;

(i) Providing consumers with access to their EHR or other clinical information, and providing access to their family members and authorized representatives if the beneficiary provides written authorization to do so;

(j) Developing family support materials and services, including creating family support groups where appropriate;

(k) Include the consumer family in the quality improvement process including surveys to capture their experience with Health Home services; and

(l) Facilitate referrals to support services that are available in the individual's community and assist with the establishment of and connection to natural supports.

Subsection 2511.2 of Section 2511, REFERRAL TO COMMUNITY AND SOCIAL SUPPORT SERVICES, is amended as follows:

2511.2 The types of community and social support services to which consumers will be referred to may include, but are not limited to:

(a) Wellness programs, including smoking cessation, fitness, weight loss programs;

(b) Specialized support groups (*i.e.*, cancer, diabetes support groups, and others);

(c) Substance use recovery support groups;

(d) Housing resources;

(e) The Supplemental Nutrition Assistance Program;

(f) Legal assistance resources;

(g) Faith-based organizations;

(h) Access to employment and educational program or training;

(i) Financial assistance, such as Temporary Assistance for Needy Families or Social Security

(j) Child care; and

(k) Social integration.

The following subsections of Section 2512, COMPREHENSIVE CARE PLAN, are amended as follows:

2512.1 A Comprehensive Care Plan (CCP) is the document that drives the delivery of all services. The CCP shall be the plan that collates all the consumer's services and providers of service in order to reduce any instances of duplication of service, prioritize the consumer's goal(s) and monitor the progress of the goal(s) in the plan.

2512.2 The development of a CCP shall include:

(a) Active participation and partnership with the consumer;

(b) Risk factors identified from the completion of the comprehensive health assessment. The assessment includes a physical health, behavioral health, substance-use and socioeconomic assessment;

(c) The consumer's goals as identified by the comprehensive health assessment, prioritized and the timeframes and strategies for addressing each;

(d) The delineation of the specific roles and responsibilities of the members of the Health Home Team who are assisting the consumer in achieving his/her goals;

(e) The signature of all participants in the development of the CCP. The Nurse Care Manager or the Primary Care Liaison from the Health Home Team must participate in the care planning process and sign the plan; and

(f) All services the Health Home provider delivers to the consumer.

…

2512.4 The CCP shall be developed in coordination with the consumer's healthcare providers. If the Health Home team develops the CCP, the MHRS Individual Recovery Plan (IRP), developed in accordance with Section 3408 of Chapter 34 of this title, shall be incorporated into the CCP. If the MHRS team develops the care plan the Health Home team will collaborate and participate in the care planning process to ensure the care plan is comprehensive.

The following subsections of Section 2513, HEALTH HOME STAFFING REQUIREMENTS, are amended as follows:

2513.1 Health Homes shall have the following staff:

(a) Health Home Director;

(b) Nurse Care Manager(s); and

(c) Primary Care Liaison.

…

2513.4 The Primary Care Liaison shall be staffed with a licensed clinician or combination of clinicians based on the needs of the individual Health Home consumer. The Primary Care Liaison shall have experience in the care and treatment of the serious mentally ill and be a Medical Doctor, APRN, Nutritionist, Licensed Independent Clinical Social Worker, Licensed Professional Counselor, Physician

Assistant or Registered Nurse. A provider may use a combination of these staff to meet the full time equivalent (FTE) requirement. The Primary Care Liaison shall be licensed in the District of Columbia. The Health Home provider shall ensure one (1) full-time Primary Care Liaison per five hundred (500) Health Home enrollees. The responsibilities of the Primary Care Liaison shall include the following:

(a) Provide medical consultation to the Health Home team;

(b) Coordinate care with external medical and behavioral health providers; and

(c) Assist with developing effective Health Home comprehensive care management and coordination of care protocols involving community and hospital medical providers.

2513.5 All Health Homes shall provide Health Home services in accordance with their Human Care Agreement (HCA) with the Department.

Subsections 2513.6 – 2513.8 are deleted.

Section 2514, ACUITY LEVELS, is amended to read as follows:

2514 [RESERVED]

The following subsections of Section 2515, HEALTH HOME REIMBURSEMENT, are amended as follows:

2515.1 The Department shall require all FSMHCs and CSAs certified as a Health Home provider to enter into a HCA with the Department. All payment for services shall be implemented through terms and conditions contained in the HCA and the D.C. Medicaid program.

2515.2 Only one (1) Health Home provider will receive payment for delivering Health Home services to a consumer in a particular month. A provider may not bill for ACT services for any consumer enrolled in the Health Home.

…

2515.4 The Health Home shall provide monthly a minimum of one (1) Health Home service.

The following subsections of Section 2516, HEALTH HOME RECORDS AND DOCUMENTATION REQUIREMENTS, are amended as follows:

2516.1 Each Health Home shall utilize the Department's designated electronic health record for documenting and billing all Health Home services.

…

2516.3 Health Home providers shall document each Health Home service and activity in the consumer's record in the Department's designated electronic health record. Any claim for 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. for both the beginning and ending times, during which the services were rendered (there is no-predetermined expectation of time spent with each service this requirement is only to verify when the service began and when it ended);

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

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

(e) Confirmation that the services delivered are contained in the consumer's CCP;

(f) Identification of any further actions required for the consumer'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 – 10 (ICD-10 CM) or subsequent revisions, and the service provided.

The following definitions in Subsection 2599.1 of Section 2599, DEFINITIONS, are amended as follows:

Mental Health Rehabilitation Services or MHRS – behavioral health services provided by a Department-certified community behavioral health provider

to consumers in accordance with the District of Columbia State Medicaid Plan and Chapter 34 of this subtitle.

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