DEPARTMENT OF BEHAVIORAL HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Acting 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, on an emergency basis, of a new Chapter 25, entitled "Health Home Certification Standards", of Subtitle A (Mental Health) of Title 22 (Health) of the District of Columbia Municipal Regulations (DCMR).

The purpose of Chapter 25 is to create standards for Core Service Agencies (CSAs) that seek certification as Health Home providers. A Health Home is a service delivery model that focuses on providing comprehensive care coordination centered on improving the management of chronic behavioral and physical health conditions. Health homes organize person-centered care plans that facilitate access to physical health services, behavioral health care, community-based services and supports for individuals determined eligible for Health Home services by the Department. Care coordination is provided through a team based approach and involves all health care practitioners, family members, and other social support networks identified by the consumer as relevant and necessary. The goal of the Health Homes service delivery model is to improve the health and life expectancy of consumers and reduce avoidable health care costs, specifically preventable hospital admissions, readmissions, and avoidable emergency room visits, for consumers and the enrolled Health Home population as a whole.

Health Home services are Medicaid reimbursable.

Issuance of these rules on an emergency basis is necessary to ensure the provision of a care coordination services that should have a direct impact on the health of consumers. Without such a service consumers in general are expected to have a life expectancy of twenty-five years less than average. Therefore, emergency action is necessary for the in order to allow Health Home services to begin as soon as possible to ensure the health, welfare, and safety of consumers.

This first notice of the emergency and proposed rulemaking was adopted on October 22, 2015. and will remain in effect for one hundred twenty (120) days or until February 19, 2016, unless superseded by publication of another rulemaking notice in the *D.C. Register*.

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

Subtitle A, MENTAL HEALTH, of Title 22 DCMR, HEALTH, is amended by adding a new Chapter 25 to read as follows:

CHAPTER 25 HEALTH HOME CERTIFICATION STANDARDS

2500 HEALTH HOME PROGRAM

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

2500.2 A Health Home is an MHRS CSA that serves as the coordinating entity for services offered to a person with a 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.

2501 CERTIFICATION REQUIREMENTS

2501.1 No person or entity shall operate a Health Home unless certified in accordance with this chapter.

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

(a) Current certification as an MHRS CSA in accordance with Chapter 34 of this subtitle;

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

(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 An MHRS CSA seeking certification shall submit an application in a format established by the Department.

2501.4 The Department shall process applications for certification as a Health Home provider in accordance with the procedures for MHRS certification in Subsection 3401 of Chapter 34 of this subtitle.

2501.5 Initial certification as a Health Home program is effective for a one (1)-year period. Certification shall remain in effect until it expires, is revoked or the provider is re-certified in accordance with Section 2502 of this chapter.

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 staff: Health Home Director, Primary Care Liaison, Nurse Care Manager (s) and Care Coordinators. No provider shall add additional Health Home teams unless the addition is approved by the Department.

2501.7 Certification is not transferable to any other organization.

2501.8 Nothing in these rules shall be interpreted to mean that certification is a right or an entitlement. Certification as a provider depends upon the Director's assessment of the need for additional Health Home providers.

2501.9 Corrective action plans and decertification of Health Home providers shall comply with the procedures set forth in Chapter 34 of this subtitle.

2502 RECERTIFICATION REQUIREMENTS

2502.1 Recertification applications shall be processed in accordance with the requirements in Section 3401 of Chapter 34 and Section 2501 of this chapter.

2502.2 Subject to Subsection 2502.3, recertification is effective for a two (2)-year period from the date of issuance of recertification by the Department.

2502.3 The Department may conditionally recertify a Health Home for a period not to exceed one (1) year if the Health Home has not met one or more terms of its HCA during the previous certification period. The Department shall issue and enforce a Corrective Action Plan (CAP) for any conditional recertification. The Department shall not recertify any Health Home that has failed to satisfy the terms of the CAP.

2502.4 Recertification is not transferable to any other provider organization.

2503 EXEMPTIONS FROM CERTIFICATION STANDARDS

2503.1 Upon good cause shown, the Department may, at its discretion, exempt a provider from a certification standard if the exemption does not jeopardize the health and safety of clients, infringe on client rights, or diminish the quality of the service

delivery.

2503.2 If the Department approves an exemption, such exemption shall end on the expiration date of the program certification, or at an earlier date if specified by the Department, unless the provider requests renewal of the exemption and renewal is granted by the Department prior to expiration of its certificate or the earlier date set by the Department.

2503.3 The Department may revoke an exemption that it determines is no longer appropriate.

2503.4 All requests for an exemption from certification standards must be submitted in writing to the Department.

2504 HEALTH HOME SERVICES ELIGIBILITY

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; 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 A consumer currently enrolled in Assertive Community Treatment is not eligible to receive Health Home services.

2504.3 A consumer may only be enrolled with one (1) Health Home at a time.

2505 HEALTH HOME SERVICES

2505.1 Health Home providers shall provide the following services to each Health Home enrollee in an individualized manner as determined by the consumer's care plan:

(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.

2506 COMPREHENSIVE CARE MANAGEMENT

2506.1 Comprehensive Care Management is the assessment and identification of health risks leading to the development and implementation of a care plan that addresses these 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.

2506.2 Comprehensive Care Management consists of the:

(a) Assessment of health risks and identification of high risk sub groups;

(b) Identification of service needs of consumers and construction of a comprehensive care plan addressing physical and behavioral health chronic conditions, current health status, and goals for improvement (see Section 2512 in this chapter);

(c) Assignment of different care management roles for a consumer to members of the Health Home Team;

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

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

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

(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.

2507 CARE COORDINATION

2507.1 Care Coordination is the 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:

(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 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; and

(l) Coordination with other health care providers.

2508 COMPREHENSIVE TRANSITIONAL CARE

2508.1 Comprehensive Transitional Care is a set of actions designed to ensure the coordination and continuity of health care as consumers transfer between different locations or different levels of care. Comprehensive transitional care includes assistance with discharge planning from inpatient settings. It also includes:

(a) Contact with the consumer within forty-eight (48) hours of the completed transition;

(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 mental 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; and

(e) Developing mental health relapse prevention and illness management strategies and plans.

2509 HEALTH PROMOTION

2509.1 Health Promotion services involve the provision of health education to the consumer and as appropriate the consumer's family member(s) and significant others specific to his/her chronic illness or needs as identified in the initial assessment and ongoing as services are provided. 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; these may include 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) Mental health education, support and consultation to consumers' families and their support system, which is directed exclusively to the well-being and benefit of the consumer; and

(f) Assisting the consumer in symptom self-monitoring and self-management for the identification and minimization of the negative effects of psychiatric symptoms, which interfere with the consumer's daily living, financial management, personal development, or school or work performance.

2510 INDIVIDUAL AND FAMILY SUPPORT SERVICES

2510.1 Individual and family support services include the ways a Health Home supports the consumers and their support teams (including families and authorized representatives) in meeting the range of psychosocial needs and accessing resources (*e.g.*, medical transportation; language interpretation; appropriate literacy materials; and other benefits to which they may be eligible or need). The services provide for continuity in relationships between the consumers/families

with their physicians and other health service providers and can include communicating on the consumers' and families' behalf.

2510.2 Individual and Family Support Services include:

(a) Assistance and support for the consumer in stressor situations;

(b) Mental health education, support and consultation to consumers' families and their support systems, which is directed exclusively to the well-being and benefit of the consumers;

(c) Developing mental health relapse prevention and illness management strategies and plans;

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

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

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

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

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

(i) 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.

2511 REFERRAL TO COMMUNITY AND SOCIAL SUPPORT SERVICES

2511.1 Referral to Community and Social Support Services includes the provision of referrals to a wide array of support services that will help consumers overcome access or service barriers, increase self-management skills and achieve overall health. Specifically, this activity involves facilitating access to support and assistance for consumers to address medical, behavioral, educational, social, and community issues that may impact overall health.

2511.2 The types of community and social support services to which consumers will be referred 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; and

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

2512 COMPREHENSIVE CARE PLAN

2512.1 A Comprehensive Care Plan (CCP) is the authorizing document for the delivery of all Health Home services.

2512.2 The development of a CCP shall include:

(a) Active participation and partnership with the consumer;

(b) A comprehensive physical health, behavioral health and socioeconomic assessment;

(c) The consumer's goals as identified by the comprehensive assessment 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 including the Nurse Care Manager as the approving authority for the CCP; and

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

2512.3 The CCP shall be updated every one-hundred eighty (180) days or more often if the consumer's needs or acuity level changes.

2512.4 The consumer's Individual Recovery Plan (IRP), developed in accordance with Section 3408 of Chapter 34 of this title shall be incorporated into the CCP and may be used to satisfy the behavioral health assessment referenced in Subsection 2512.2(b) above. The IRP may be developed within the CCP but the requirements of Subsection 3408 of Chapter 34 of this title must be satisfied.

2513 HEALTH HOME STAFFING REQUIREMENTS

2513.1 Health Homes shall have the following staff:

(a) Health Home Director;

(b) Nurse Care Manager(s);

(c) Primary Care Liaison; and

(d) Care Coordinator(s)

2513.2 The Health Home Director shall be responsible for managing the CSA's Health Home program. The Health Home Director shall have a Master's level education in a health-related field. There shall be a point five (.5) Full Time Equivalent staff person for every Health Home Team of three hundred (300) consumers.

2513.3 The Nurse Care Manager shall be an Advanced Practice Registered Nurse (APRN) or Registered Nurse (RN) with relevant experience and expertise in care of physical health care. The Nurse Care Manager shall lead and/or manage team-based assessment, care plan development and care plan implementation activities. The Health Home provider shall ensure one (1) full-time Nurse Care Manager per one hundred and fifty (150) enrolled Health Home consumers.

2513.4 The Primary Care Liaison shall be a Medical Doctor or APRN. The Primary Care Liaison shall be licensed in the District of Columbia and have experience in the care and treatment of the serious mentally ill. 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 A Care Coordinator shall have a Bachelor's degree in a health or public health-related field with training in a care coordinator role or equivalent experience, skills and aptitudes to meet functional requirements of the Health Home care coordinator role. A Care Coordinator shall provide supports to the Health Home team and individual consumers as part of the implementation of the CCP activities. The ratio of a Care Coordinator to consumers shall not exceed 1:60.

2513.6 Responsibilities of the Care Coordinator shall include the following:

(a) Provide and assist in the provision of Home Health services as stated on the care plan;

(b) Coordinate behavioral health care, substance abuse, and health care services informed by evidence-based clinical practice guidelines, including prevention of mental illness and substance use disorders;

(d) Coordinate access to preventive and health promotion services;

(e) Coordinate access to chronic illness management, including self-management support to individuals and their families; and

(f) Coordinate access to individual and family supports, including referral to community, social support, and recovery services.

2513.7 Care Coordinators shall provide services under the supervision of a Qualified Practitioner.

2513.8 All Health Homes shall provide Health Home services in accordance with their HCA with the Department.

2514 ACUITY LEVELS

2514.1 The Department shall assign each Health Home consumer into either a high- or low-acuity category.

2514.2 A High Acuity adult consumer is a consumer with serious and persistent mental illness and at least one (1) high-cost condition (*i.e.*, cancer; coronary artery disease; diabetes; peripheral vascular disease; congestive heart failure; cirrhosis; HIV; lung disease; multiple sclerosis; quadriplegia; seizure disorders; rheumatoid arthritis) and a history in the past year of:

(a) A high-cost chronic medical condition and one (1) non-psychiatric hospitalization; or

(b) Two (2) or more non-psychiatric hospitalizations; or

(c) One (1) psychiatric hospitalization.

2514.3 A low-acuity consumer is an adult consumer with serious and persistent mental illness who does not qualify as a high-acuity consumer.

2515 HEALTH HOME REIMBURSEMENT

2515.1 The Department shall require all CSAs certified as Health Home providers to enter into an 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 A CSA also certified as a Health Home may not bill MHRS Community Support for a consumer enrolled in the Health Home.

2515.3 Reimbursement for Health Home services is on a PMPM rate as published by the Department of Health Care Finance. The month time period shall begin on the first (1st) of the month and end on the last day of the month. In order to qualify for the monthly rate, Health Home providers shall provide and document the required services provided during the month for which reimbursement is claimed.

2515.4 For a consumer enrolled in a high-acuity band, the Health Home shall provide, at a minimum, and shall document in the consumer's chart the following services, at least one of which must be provided as a face-to-face service:

(a) Two (2) care management services; and

(b) At least two (2) other Health Home services.

2515.5 For a consumer enrolled in a low-acuity band, the Health Home shall provide at a minimum one (1) care management service and one (1) other Health Home service.

2515.6 Only one (1) Health Home will receive payment for delivering Health Home services to a consumer in a particular month.

2516 HEALTH HOMES RECORDS AND DOCUMENTATION REQUIREMENTS

2516.1 Each Health Home shall utilize the Department's electronic record system, iCAMS, for documenting and billing all Health Home services.

2516.2 Health Home providers shall maintain all Health Home consumer information in accordance with federal and District privacy laws and the Department's Privacy Manual.

2516.3 Health Home providers shall document each Health Home service and activity in the consumer's iCAMS 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. (beginning and ending), during which the services were rendered;

(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 – 9 (ICD-9 CM) or subsequent revisions, and the service provided.

2516.4 No Health Home provider shall be reimbursed for a claim for services that does not meet the requirements of this section or is not documented in accordance with this section.

2516.5 Health Home providers shall implement a compliance program that regularly reviews submitted claims and identifies errors and overpayments. Health Home providers shall repay any paid claims that do not meet reimbursement criteria within sixty (60) days of discovery.

2599 **DEFINITIONS**

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

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

Chronic Physical Condition – a somatic health condition, such as asthma, cardiovascular disease, diabetes, substance use disorder, and/or Human Immunodeficiency Virus.

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

Consumer – a person who seeks or receives mental health services or mental health supports funded or regulated by the Department.

Core Services Agency or CSA – a community-based provider that has entered into a Human Care Agreement with the Department to provide specific MHRS in accordance with the requirements of Chapter 34 of this subtitle.

Cultural and Linguistic Competence - a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. Culture refers to integrated patterns of health human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, institutions of racial, ethnic, religious or social groups. Competence implies having the capacity to function effectively as individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

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

Health Home – an entity that is certified by the Department of Behavioral Health, that uses a patient-centered approach to coordinate a consumer's behavioral, primary, acute or other specialty medical health care services.

Health Home Team – the Health Home staff that delivers services to a specific group of consumers in their assigned Health Home teams. A Health Home Team includes the Health Home Director, Primary Care Liaison, Nurse Care Manager(s) and Care Coordinator(s).

High Cost Chronic Medical Conditions – medical conditions that create the need for intensive or long-term treatment and therefore make the cost of the individual's treatment higher than the average Medicaid beneficiary

Mental Health Rehabilitation Services or MHRS –palliative services provided by a Department-certified community mental health provider to consumers in accordance with the District of Columbia State Medicaid Plan, the Medical Assistance Administration (MAA) (now Department of Health Care Finance (DHCF))/ Department Interagency Agreement, and Chapter 34 of this subtitle.

Qualified Practitioner – a psychiatrist, psychologist, licensed independent clinical social worker, advance practice registered nurse, registered nurse, licensed professional counselor or licensed independent social worker.

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-IV or its ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance abuse disorders, intellectual disabilities and other developmental disorders, or seizure disorders, unless those exceptions co-occur with another diagnosable mental illness.

Specialty Provider – a community-based organization MHRS provider certified by Department to provide specialty services either directly or through contract.

All persons desiring to comment on the subject matter of this emergency and proposed rulemaking should file comments in writing not later than thirty (30) days after the date of publication of this notice in the *D.C. Register*. Comments should be filed the Department of Behavioral Health at 64 New York Avenue, N.E., 2nd Floor, Washington, D.C. 20002, or e-mailed to Suzanne Fenzel, Deputy Director, Office of Strategic Planning, Policy and Evaluation, at Suzanne.Fenzel@dc.gov. Copies of the proposed rules may be obtained from www.DBH.dc.gov or from the Department of Behavioral Health at the address above.