# Table of Contents

**State/Territory Name: District of Columbia**

**State Plan Amendment (SPA) #: 17-0007**

This file contains the following documents in the order listed:


1) Approval Letter
2) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

**Region III/Division of Medicaid and Children's Health Operations**

SWIFT # 083120174094

**October 24, 2017**

Claudia Schlosberg, J.D.
Senior Deputy Director/Medicaid Director
District of Columbia
Department of Health Care Finance
441 4th Street, N.W., 9th floor, South
Washington, D.C. 20001

**Re: Approval of Health Home State Plan Amendment DC SPA 17-0007**

Dear Ms. Schlosberg:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the District of Columbia's State Plan Amendment (SPA) Transmittal # 17-0007, My Health GPS Amendment. This amendment proposes to extend provider eligibility for a one time incentive payment to support the development of care plans for Health Home beneficiaries, beginning July 1, 2017 and ending October 31, 2017.

We are pleased to inform you that, after extensive review, this amendment is approved; its effective date is July 1, 2017. Enclosed is a copy of the approved SPA pages for incorporation into the District of Columbia State plan.

Please share with your staff my appreciation for their time and effort throughout this process. If you have any questions regarding this Health Home State Plan Amendment, please contact LCDR Frankeena Wright at 215-861-4754 or by email at Frankeena.Wright@cms.hhs.gov.

Sincerely,

Francis T. McCullough
Associate Regional Administrator

Enclosures

cc: Alice Weiss, DHCF
Sabrina Tillman Boyd, CMS

CMS-10434 OMB 0938-1188

# Approval Notice

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard, Mail Stop S2-14-26

Baltimore, Maryland 21244-1850

**Date:** 10/23/2017

**Head of Agency:** Wayne Turnage

**Title/Dept :** Director

**Address 1:** 441 4th Street, NW

**Address 2:**

**City :** Washington

**State:** DC

**Zip:** 20001

**MACPro Package ID:** DC2017MS0009O

**SPA ID:** DC-17-0007

**Subject**

Approval of DC SPA 17-0007

**Dear Wayne Turnage**

This is an informal communication that will be followed with an official communication to the State's Medicaid Director.

The Centers for Medicare and Medicaid Services (CMS) is pleased to inform you that we are recommending approval for your request for

My Health GPS Health Home SPA DC 17-0007

| Reviewable Unit | Effective Date |
|---|---|
| Health Homes Payment Methodologies | 7/1/2017 |

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the District of Columbia's State Plan Amendment (SPA) Transmittal # 17-0007, My Health GPS Amendment. This amendment proposes to extend provider eligibility for a one time incentive payment to support the development of care plans (as described in the definition of Comprehensive Care Management) for HH beneficiaries, beginning July 1, 2017 and ending October 31, 2017.

**Sincerely,**

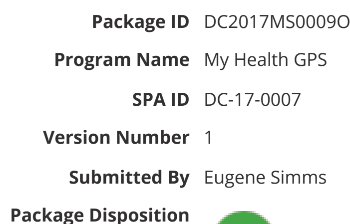
Francis McCullough

Associate Regional Administrator

# Approval Documentation

| Name | Date Created | Type |
|---|---|---|
| No items available | | |

# Package Information

| | | | |
|---|---|---|---|
| **Package ID** | DC2017MS0009O | **Submission Type** | Official |
| **Program Name** | My Health GPS | **State** | DC |
| **SPA ID** | DC-17-0007 | **Region** | Philadelphia, PA |
| **Version Number** | 1 | **Package Status** | Approved |
| **Submitted By** | Eugene Simms | **Submission Date** | 9/1/2017 |
| **Package Disposition** |  | **Approval Date** | 10/23/2017 4:16 PM EDT |

**Priority Code** P3

# Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | DC2017MS0009O | DC-17-0007 | My Health GPS

Not Started In Progress Complete

## Package Header

**Package ID** DC2017MS0009O

**SPA ID** DC-17-0007

**Submission Type** Official

**Initial Submission Date** 9/1/2017

**Approval Date** 10/23/2017

**Effective Date** N/A

**Superseded SPA ID** N/A

## State Information

**State/Territory Name:** District of Columbia

**Medicaid Agency Name:** Department of Health Care Finance

## Submission Component

(selected) State Plan Amendment

(selected) Medicaid

( ) CHIP

## Submission Type

(selected) Official Submission Package

( ) Draft Submission Package

**Allow this official package to be viewable by other states?**

( ) Yes

(selected) No

## Key Contacts

| Name | Title | Phone Number | Email Address |
|---|---|---|---|
| Weiss, Alice | Director/HCPRA | (202)442-9107 | alice.weiss@dc.gov |

## SPA ID and Effective Date

**SPA ID** DC-17-0007

| Reviewable Unit | Proposed Effective Date |
|---|---|
| Health Homes Payment Methodologies | 8/12/2017 |

## Executive Summary

**Summary Description Including Goals and Objectives** The District of Columbia's (DC) Department of Health Care Finance (DHCF) developed DC's Health Home (HH) State Plan benefit for beneficiaries with three or more chronic conditions. The goals of DHCF's HH program for beneficiaries with three or more chronic conditions are to improve the integration of medical and behavioral health, community supports and social services, to lower rates of avoidable emergency department (ED) use, to reduce preventable hospital admissions and readmissions, to reduce healthcare costs, to improve the experience of care, quality of life and beneficiary satisfaction, and to improve health outcomes. Under DHCF's approach, the HH will be the central point for coordinating patient-centered and population-focused care for beneficiaries with three or more chronic conditions. . HH providers will be embedded in the primary care setting to effectively manage the full breadth of beneficiary needs. A beneficiary can only be enrolled and receive HH services from one HH at a time. DHCF will ensure payments to HH providers do not duplicate payments for comparable services financed by Medicaid. HH services will be consistent with, but not limited to, those set forth under 42 CFR 440.169.

## Dependency Description

**Description of any dependencies between this submission package and any other submission package undergoing review**

## Disaster-Related Submission

**This submission is related to a disaster**

- ○ Yes
- ● No

## Federal Budget Impact and Statute/Regulation Citation

**Federal Budget Impact**

| | Federal Fiscal Year | Amount |
|---|---|---|
| First | 2017 | $3589998 |
| Second | 2018 | $7229023 |

**Federal Statute / Regulation Citation**

42 USC § 1396w-4

## Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ● Other

**Describe** D.C. Act: 21-463

## Authorized Submitter

**The following information will be provided by the system once the package is submitted to CMS.**

**Name of Authorized Submitter** Eugene Simms

**Phone number** 4437972529

**Email address** eugene.simms@dc.gov

**Authorized Submitter's Signature** Eugene Simms

☑ I hereby certify that I am authorized to submit this package on behalf of the Medicaid Agency.

# Submission - Public Comment

MEDICAID | Medicaid State Plan | Health Homes | DC2017MS0009O | DC-17-0007 | My Health GPS

Not Started In Progress Complete

## Package Header

**Package ID** DC2017MS0009O

**Submission Type** Official

**Approval Date** 10/23/2017

**Superseded SPA ID** N/A

**SPA ID** DC-17-0007

**Initial Submission Date** 9/1/2017

**Effective Date** N/A

**Name of Health Homes Program**

My Health GPS

**Indicate whether public comment was solicited with respect to this submission.**

- ○ Public notice was not federally required and comment was not solicited
- ● Public notice was not federally required, but comment was solicited
- ○ Public notice was federally required and comment was solicited

**Indicate how public comment was solicited:**

☐ Newspaper Announcement

☑ Publication in state's administrative record, in accordance with the administrative procedures requirements

**Date of Publication:** Aug 11, 2017

☐ Email to Electronic Mailing List or Similar Mechanism

- [ ] Website Notice
- [ ] Public Hearing or Meeting
- [ ] Other method

**Upload copies of public notices and other documents used**

| Name | Date Created | Type |
|---|---|---|
| My Health GPS Amdt_Register Notice_August 11 2017 | 9/1/2017 12:27 PM EDT | PDF |

**Upload with this application a written summary of public comments received (optional)**

| Name | Date Created | Type |
|---|---|---|
| No items available | | |

**Indicate the key issues raised during the public comment period (optional)**

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

# Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | DC2017MS0009O | DC-17-0007 | My Health GPS

Not Started    In Progress    Complete

## Package Header

**Package ID** DC2017MS0009O

**SPA ID** DC-17-0007

**Submission Type** Official

**Initial Submission Date** 9/1/2017

**Approval Date** 10/23/2017

**Effective Date** N/A

**Superseded SPA ID** N/A

**Name of Health Homes Program**

My Health GPS

**One or more Indian health programs or Urban Indian Organizations furnish health care services in this state**

- ( ) Yes
- (•) No

# Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | DC2017MS0009O | DC-17-0007 | My Health GPS

Not Started    In Progress    Complete

## Package Header

| | | | |
|---|---|---|---|
| **Package ID** | DC2017MS0009O | **SPA ID** | DC-17-0007 |
| **Submission Type** | Official | **Initial Submission Date** | 9/1/2017 |
| **Approval Date** | 10/23/2017 | **Effective Date** | N/A |
| **Superseded SPA ID** | N/A | | |

## SAMHSA Consultation

**Name of Health Homes Program**

My Health GPS

☑ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

| Date of consultation |
|---|
| 11/10/2016 |

# Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | DC2017MS0009O | DC-17-0007 | My Health GPS

Not Started In Progress Complete

## Package Header

| | | | |
|---|---|---|---|
| **Package ID** | DC2017MS0009O | **SPA ID** | DC-17-0007 |
| **Submission Type** | Official | **Initial Submission Date** | 9/1/2017 |
| **Approval Date** | 10/23/2017 | **Effective Date** | 7/1/2017 |
| **Superseded SPA ID** | DC-16-0012<br>System-Derived | | |

## Payment Methodology

**The State's Health Homes payment methodology will contain the following features**

☑ Fee for Service

- ☐ Individual Rates Per Service
- ☑ Per Member, Per Month Rates
  - ☑ Fee for Service Rates based on
    - ☑ Severity of each individual's chronic conditions
    - ☑ Capabilities of the team of health care professionals, designated provider, or health team
    - ☐ Other
- ☐ Comprehensive Methodology Included in the Plan
- ☑ Incentive Payment Reimbursement
  - ☑ Fee for Service Rates based on
    - ☐ Severity of each individual's chronic conditions
    - ☐ Capabilities of the team of health care professionals, designated provider, or health team
    - ☑ Other

**Describe below**

DHCF plans to implement a pay-for-performance component that provides incentive payments to HH providers for achieving quality/performance benchmarks. DHCF will ensure the methodology used to calculate and disburse incentive payments is consistent with the HH program goals of efficiency, economy and quality. Beginning July 1, 2017 and ending October 31, 2017, HH providers will be eligible for a one time incentive payment to support the development

of care plans (as described in the definition of Comprehensive Care Management) for HH beneficiaries. Further guidance on the incentive payment will be outlined in the DCMR. HH providers will also be eligible to receive an annual pay-for-performance bonus payment, no sooner than the last quarter of the second full Fiscal Year after the effective date of the program. HH provider performance will be evaluated by process, efficiency, and outcome categories. DHCF will inform HH providers prior to the start of each Fiscal Year the target performance for each measure category, based on an analysis of prior performance. HH providers will be subject to a percentage withhold of their PMPM, no sooner than the first quarter of the second full Fiscal Year after the effective date of the program. The HH provider must achieve the target performance for each measure in the category to achieve the incentive payment for that category. HH providers may earn an incentive payment higher than the amount withheld. Further guidance on the pay-for-performance component will be outlined in the DCMR, available at: www.dcregs.dc.gov, with an effective date of July 1, 2017.

**Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided**

DHCF will use two (2) per member per month (PMPM) rates to reimburse for HH services that differ based on the assessed acuity of the Medicaid beneficiary. DHCF developed these rates by analyzing FY 2014 and 2015 Medicaid claims data to identify the most common chronic conditions associated with more frequent ER use and/or hospital admissions. Through the analysis, DHCF identified the top sixteen (16) chronic conditions, which include: mental health conditions (depression, personality disorders); substance use disorders; asthma (+COPD); diabetes; heart disease (CHF, conduction disorders/cardiac dysrhythmias, myocardial infarction, pulmonary heart disease); BMI over 25 (morbid obesity only); cerebrovascular disease; chronic renal failure [on dialysis]; hepatitis; HIV; hyperlipidemia; hypertension; malignancies; paralysis; peripheral atherosclerosis; and sickle cell anemia. DHCF will utilize a risk adjustment tool to determine the risk for future hospital utilization, and target and stratify the population into two acuity cohorts: Group 1 (lower risk) and Group 2 (higher risk). The methodology will be used to place the higher risk beneficiaries in Group 2 and the remainder of eligible beneficiaries in Group 1.

The two (2) resulting rates are based on the DHCF HH staffing model and reflect the average expected service intensity for those receiving HH services, and will be set in accordance with Section 1902(a)(30)(A) of the Social Security Act (42 U.S.C. § 1396a(a)(30)(A)). DHCF will pay a higher PMPM rate for beneficiaries in Group 2 (higher acuity) due to a higher expected need for HH services and requisite staff. The base PMPM rates for both Group 1 (lower acuity) and Group 2 (higher acuity) account for the regionally adjusted salaries for the required HH staff (including fringe costs) and is adjusted based on staffing ratios per acuity group. Two (2) payment enhancements are added on top of both base rates: 1) to reflect overhead or administrative costs; and 2) to support HH providers in meeting the health information technology requirements. The payment methodology and rates will be further outlined in the DCMR. DHCF will review the HH rates annually and re-base as necessary.

In order to receive the first PMPM payment for an eligible HH beneficiary, a HH provider must inform the HH beneficiary about available HH services, receive the beneficiary's consent to receive HH services, and begin the development of a care plan. The development of the care plan will follow standards for Comprehensive Care Management described below. HH providers must deliver at least one (1) HH service within the calendar month to the eligible HH beneficiary in order to receive a PMPM that month. For beneficiaries in Group 1, the HH service does not need to be delivered in-person for the provider to be eligible for the PMPM payment. For beneficiaries in Group 2, at least one (1) HH service needs to be delivered in-person for the provider to be eligible for the PMPM payment. Providers will submit claims via MMIS using a specific procedure code for health home services. Additionally, providers will be required to utilize a modifier on the procedure code that itemizes which of the health home services was delivered.

Any claim for program services shall be supported by written documentation in the EHR and the DCMR will provide clear instructions on minimum documentation requirements. All claims for health home services will be subject to regular audits to ensure that Medicaid payments made to health home providers are consistent with efficiency, economy and quality of care, and made in accordance with federal and District conditions of payment.

Information on the PMPM rates will be made available through the DCMR, available at: www.dcregs.dc.gov, with an effective date of July 1, 2017.

HH rates will be made available on the DHCF fee schedule at https://www.dc-medicaid.com/dcwebportal/home.

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

## Agency Rates

**Describe the rates used**

- ◯ FFS Rates included in plan
- ◉ Comprehensive methodology included in plan
- ◯ The agency rates are set as of the following date and are effective for services provided on or after that date

## Rate Development

**Provide a comprehensive description in the SPA of the manner in which rates were set**

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

**Comprehensive Description**

DHCF will use two (2) per member per month (PMPM) rates to reimburse for HH services that differ based on the assessed acuity of the Medicaid beneficiary. DHCF developed these rates by analyzing FY 2014 and 2015 Medicaid claims data to identify the most common chronic conditions associated with more frequent ER use and/or hospital admissions. Through the analysis, DHCF identified the top sixteen (16) chronic conditions, which include: mental health conditions (depression, personality disorders); substance use disorders; asthma (+COPD); diabetes; heart disease (CHF, conduction disorders/cardiac dysrhythmias, myocardial infarction, pulmonary heart disease); BMI over 25 (morbid obesity only); cerebrovascular disease; chronic renal failure [on dialysis]; hepatitis; HIV; hyperlipidemia; hypertension; malignancies; paralysis; peripheral atherosclerosis; and sickle cell anemia. DHCF will utilize a risk adjustment tool to determine the risk for future hospital utilization, and target and stratify the population into two acuity cohorts: Group 1 (lower risk) and Group 2 (higher risk). The methodology will be used to place the higher risk beneficiaries in Group 2 and the remainder of eligible beneficiaries in Group 1.

The two (2) resulting rates are based on the DHCF HH staffing model and reflect the average expected service intensity for those receiving HH services, and will be set in accordance with Section 1902(a)(30)(A) of the Social Security Act (42 U.S.C. § 1396a(a)(30)(A)). DHCF will pay a higher PMPM rate for beneficiaries in Group 2 (higher acuity) due to a higher expected need for HH services and requisite staff. The base PMPM rates for both Group 1 (lower acuity) and Group 2 (higher acuity) account for the regionally adjusted salaries for the required HH staff (including fringe costs) and is adjusted based on staffing ratios per acuity group. Two (2) payment enhancements are added on top of both base rates: 1) to reflect overhead or administrative costs; and 2) to support HH providers in meeting the health information technology requirements. The payment methodology and rates will be further outlined in the DCMR. DHCF will review the HH rates annually and re-base as necessary.

In order to receive the first PMPM payment for an eligible HH beneficiary, a HH provider must inform the HH beneficiary about available HH services, receive the beneficiary's consent to receive HH services, and begin the development of a care plan. The development of the care plan will follow standards for Comprehensive Care Management described below. HH providers must deliver at least one (1) HH service within the calendar month to the eligible HH beneficiary in order to receive a PMPM that month. For beneficiaries in Group 1, the HH service does not need to be delivered in-person for the provider to be eligible for the PMPM payment. For beneficiaries in Group 2, at least one (1) HH service needs to be delivered in-person for the provider to be eligible for the PMPM payment. Providers will submit claims via MMIS using a specific procedure code for health home services. Additionally, providers will be required to utilize a modifier on the procedure code that itemizes which of the health home services was delivered.

Any claim for program services shall be supported by written documentation in the EHR and the DCMR will provide clear instructions on minimum documentation requirements. All claims for health home services will be subject to regular audits to ensure that Medicaid payments made to health home providers are consistent with efficiency, economy and quality of care, and made in accordance with federal and District conditions of payment.

Information on the PMPM rates will be made available through the DCMR, available at: www.dcregs.dc.gov, with an effective date of July 1, 2017.

HH rates will be made available on the DHCF fee schedule at https://www.dc-medicaid.com/dcwebportal/home.

## Assurances

☑ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

**Describe below how non-duplication of payment will be achieved**

DHCF will ensure that HH service payments will not duplicate payment for Medicaid-funded services offered through another method (i.e. managed care, 1915(c) waivers, any future HH state plan benefits, and other state plan services). DHCF will utilize the DCMR, provider guidance materials, and MOAs to clarify roles of providers offering similar services to promote a complementary system of services that advances whole-person care and ensures non-duplication of payment or services. In instances of known duplication, DHCF will leverage its Medicaid Management Information System (MMIS) to systematically restrict duplicative provider payments. Programs with services similar to HH and DHCF's strategy to address them are outlined below.
DC has two 1915(c) waivers, the Elderly and Persons with Physical Disabilities (EPD) Waiver and the Individuals with Intellectual and Developmental Disabilities (IDD) Waiver. Both waivers provide Medicaid-reimbursable case management services. Currently, EPD case managers receive reimbursement to develop and execute a person-centered care plan for beneficiaries enrolled in the EPD Waiver program. Functions provided by EPD case managers also include assessments to determine unmet needs related to waiver services, planning of services provided under the waiver, submission of requests

for the authorization of waiver services, and monitoring of service provision. Similarly, IDD service coordinators currently receive reimbursement to coordinate and facilitate the provision of quality services and supports, review the implementation and delivery of services and supports identified in the Individual Support Plan (ISP), take corrective action as necessary, assist with problem solving, and advocate for the person and his/her family. To prevent duplication of services, DHCF will establish a process to ensure beneficiaries receiving case management services from the EPD or IDD waiver will not concurrently receive HH services.
HH services will add to, and not duplicate, the clinical care coordination services provided under the Adult Substance Abuse Rehabilitative Services (ASARS) Medicaid State Plan benefit, where clinical coordinators focus on ways to ensure care plans include services that address a beneficiary's substance use disorder. To prevent duplication of services, DHCF will establish a process to ensure HH providers coordinate and collaborate with the ASARS providers and leverage their work in order to advance the "whole-person" approach to care and supports the beneficiary's full array of clinical and non-clinical health care needs.
HHs will partner with DC Medicaid MCOs through MOAs containing clearly defined roles and responsibilities for each party. Additional guidance will be supplied to HHs and MCOs in the DCMR and MCO contracts in order to avoid duplicative efforts and to ensure timely communication, care transition planning, use of evidence-based referrals, and follow-up consultations with appropriate health service providers. HHs will include the MCO, as appropriate, when creating or updating the HH care plan. The HHs and MCOs will be expected to develop protocols for sharing information on care planning and patient care. HHs will identify any gaps in service needs for HH enrolled beneficiaries regardless of the programs from which the beneficiaries receive services.
When applicable to a particular HH provider that is otherwise reimbursed for providing care management or coordination services, DHCF will prevent duplicative payments by furnishing a differential payment to that provider, reducing payment by the amount of the duplicative service. Additionally, a beneficiary may not be enrolled in more than one HH in a given month.
DHCF does not cover targeted case management services under 1915(g). As such, there is no risk of duplication of payment for targeted case management services.

- [x] The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
- [x] The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- [x] The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

## Optional Supporting Material Upload

| Name | Date Created | Type |
|---|---|---|
| | No items available | |

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

*This view was generated on 10/23/2017 4:41 PM EDT*