

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



My Health GPS Provider Operational Manual
Medicaid Health Home Benefit for Individuals with Three or More Chronic Illnesses

Health Care Delivery Management Administration

The purpose of this document is to provide information related to services, provider participation, payment and system requirements necessary for the implementation and operation of the Health Home Benefit for Medicaid eligible individuals with three or more chronic illnesses. This manual does not replace the Regulations but serves as a guide for *My Health GPS* Providers.



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I. Introduction

The *My Health GPS* Program is established as a Health Home under the authority of Section 1945 of the Social Security Act for District Medicaid beneficiaries who have three (3) or more qualifying chronic conditions. DHCF launched the *My Health GPS* Program on July 1, 2017, to approved primary care providers who deliver comprehensive care management services to the District's Medicaid beneficiaries with three (3) or more qualifying chronic conditions. The *My Health GPS* Program is one of the District of Columbia's Medicaid initiatives that focuses on providing individualized person-centered case management and care coordination. This program addresses the unmet care management needs of beneficiaries with preventable utilization of emergency medical services, avoidable emergency department services, hospital admissions, potentially preventable readmissions and poor health outcomes. *My Health GPS* services are delivered by an interdisciplinary team in the primary care setting, that coordinates patient-centered and population-focused care for these beneficiaries.

II. Statutory Authority of Health Homes

Establishing a Health Home program is an option afforded to States under Section 2703 of the Affordable Care Act. Effective January 1, 2011, Section 2703 allows states (under the State Plan option or through a Waiver) to implement Health Homes. The purpose of Health Homes is to provide the opportunity for States to address and receive additional Federal support for the enhanced integration and coordination of primary, acute, behavioral health, and long-term services and support for persons with chronic conditions.

III. Program Overview

The *My Health GPS* Program is designed to produce the following outcomes for eligible beneficiaries:

- Lower rates of avoidable emergency department (ED) use;
- Reductions in preventable hospital admissions and re-admissions;
- Reductions in healthcare costs;
- Improvements in the experience of care, quality of life, and beneficiary satisfaction; and
- Improved health outcomes

The providers of *My Health GPS* services deliver care management services using an interdisciplinary team embedded in the primary care setting and aim to improve the integration of medical, behavioral health, community support and social services. *The beneficiary is the driver of the My Health GPS process. The My Health GPS providers gather with their team and synthesize the risk and needs of the beneficiary to ensure access to needed care and services. Each provider integrates various components of the health and social supports systems, including Health Information Exchange tools (HIE) that can be interfaced when addressing the needs of eligible beneficiaries.*

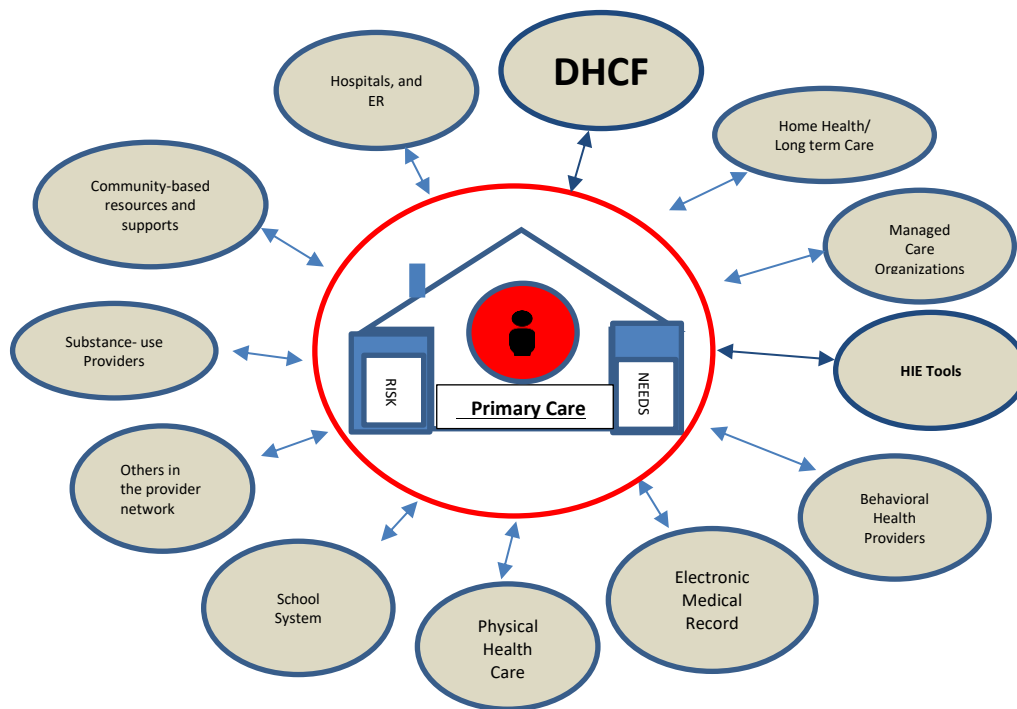




The members (beneficiaries) are stratified into two categories, low and high acuity. These two acuity levels are no longer associated with reimbursement rates, however, should support guiding quarterly engagement with an enrolled *My Health GPS* beneficiary.

The program provides two per member (beneficiary) per quarter (PMPQ) reimbursement rates to approved providers. These rates are outlined in the claims and reimbursement section of this guidance manual.

The first PMPQ rate is based on the completion of an initial or annual assessment and care plan service. The second PMPQ rate is for three remaining reimbursement quarters. The providers deliver care management services using an interdisciplinary team embedded in the primary care setting and aim to improve the integration of medical, behavioral health, community support and social services.



The *My Health GPS* State Plan Amendment can be found at: <https://dhcf.dc.gov/page/health-home-persons-multiple-chronic-conditions-my-health-gps>

The *My Health GPS* regulation can be found in the District of Columbia Municipal Regulations (DCMR) (<http://www.dcregs.dc.gov/>) under Chapter 102 of Title 29 (Public Welfare) or at: <https://dhcf.dc.gov/page/health-home-persons-multiple-chronic-conditions-my-health-gps>





IV. Provider Eligibility

A. Provider Requirements

To become an approved *My Health GPS* entity, organizations must meet or exceed the following requirements:

- a) Be a primary care provider, which includes:
 - 1) Primary Care Clinical Individual Practices
 - 2) Primary Care Clinical Group Practice; or
 - 3) Federally Qualified Health Centers (FQHC)
- b) Be enrolled as a DC Medicaid provider in accordance with the requirements set forth in Chapter 102 of Title 29 of the DCMR;
- c) Not have current or pending investigations, exclusions, suspensions or debarment from any Federal, State or District healthcare program;
- d) Not having any outstanding overpayment from DHCF; and
- e) Proof of National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Level Two recognition.
 - 1) If the applicant does not already possess the credential, the organization must submit evidence that they have initiated the NCQA PCMH application process.
 - 2) The applicant must receive the NCQA PCMH credential within twelve (12) months of the date of submission of the *My Health GPS* application
 - a. If the applicant does not receive the PCMH credentials within the outlined period, the *My Health GPS* Provider will be subject to enhanced MCO oversight until they receive the recognition
- f) In addition, the *My Health GPS* entities are required to demonstrate the following:
 - 1) Certified Electronic Health Record (EHR) with the ability to document a person-centered care plan;
 - 2) Twenty-four (24) hour, seven (7) days per week access to clinical advice, including culturally appropriate translation and interpretation services for beneficiaries with limited English proficiency;
 - 3) Meet the interdisciplinary team staffing and staffing ratios; and
 - 4) Enrollment to participate in the Health Information Exchange (HIE) to receive hospital emergency department alerts and additional information for enrolled beneficiaries. Entities must ensure that their Notice of Privacy Practices (NPP) align with the HIE.





My Health GPS providers are required to ensure that beneficiaries are fully informed about the appropriate uses, privacy and security of their Protected Health Information (PHI). The *My Health GPS* providers must include the following in the NPP:

- a) A description of HIE services, which includes:
 - 1) Which HIE provides these services;
 - 2) The types of providers with whom health information is exchanged;
 - 3) A link to information on HIE services or further information about the HIE.
- b) Explain individual's right to opt-out of the HIE, and provide information on steps to opt-out of the HIE;
- c) Explain individuals' protections against unauthorized disclosure of mental health information, pursuant to the District of Columbia Mental Health Information Act of 1978 (§§7-1201.01 to 7-1207.02).

All *My Health GPS* provider requirements are outlined in the regulation and can be found in the District of Columbia Municipal Regulations (<http://www.dcregs.dc.gov/>) under Chapter 102 of Title 29 (Public Welfare) or at: <https://dhcf.dc.gov/page/health-home-persons-multiple-chronic-conditions-my-health-gps>.

Once approved as a *My Health GPS* entity the entity must maintain their enrollment by:

- a) Participating in activities supporting the successful implementation and maintenance of the *My Health GPS* program including:
 - 1) Trainings to foster competency and development of best practice related to Person Centered planning, chronic disease self-management and relative topics;
 - 2) Continuous quality improvement task, monitoring and performance reporting;
 - 3) District-wide initiatives to support the exchange of health information
 - 4) Evaluations required by CMS, DHCF, or its Agent
- b) Maintaining compliance with all requirements, terms and conditions in the Entity's DC Medicaid Provider Agreement including all modifications, as well as, with all applicable Federal and District laws.

V. Staffing

Each *My Health GPS* provider shall be comprised, at a minimum, of the following practitioners, or comparable practitioners as approved by DHCF on a case-by-case basis:

- a) a Health Home Director, who has a master's level education in a health- related field;
- b) a Nurse Care Manager, who has an advanced practice nursing license or a Bachelor of Nursing degree with appropriate care management experience; and
- c) a Peer Navigator (Specialist), who is a health educator capable of linking beneficiaries with the health and social services they need to achieve wellness, who has either completed at least forty (40) hours of training in or has at least six (6) months of experience in community health; and





- d) a Care Coordinator, who has a bachelor's degree in social work or has a bachelor's degree in a health-related field with at least three (3) years' experience in a healthcare or human services field

The minimum staffing ratios must be in place by no later than the end of the second quarter of the *My Health GPS* entity's enrollment into the Program and shall continue to comply with the minimal staffing ratios throughout participation in the program. If the *My Health GPS* entity does not remain in compliance with staffing, the entity's census will be modified (reduced) to meet the current staffing complement (ratios). The remaining beneficiaries may be reassigned to another *My Health GPS* entity. DHCF will notify both *My Health GPS* entities, as well, as the beneficiary regarding the reassignment, in writing.

- a) Health Home Director: One half (0.5) full-time employee per four hundred (400) beneficiaries;
- b) Nurse Care Manager: Two (2) full-time employees per four hundred (400) beneficiaries;
- c) Peer Navigator (Specialist): One (1) full-time employee per four hundred (400) beneficiaries; and
- d) Care Coordinator: One (1) full-time employee per four hundred (400) beneficiaries

Staff Position	FTE	Ratio per Beneficiaries
Health Home Director	0.5	400
Nurse Care Manager	2	400
Peer Navigator (Specialist)	1	400
Care Coordinator	1	400

Alternate Staffing

My Health GPS entities can submit, in writing, an alternative staffing model to DHCF for review and consideration. Entities may not begin using the alternative staffing model until DHCF has approved their request, in writing. The submission should include a summary of the reason the entity is requesting an alternative staffing model and how the recommendation will meet the beneficiaries care management needs as outlined by the *My Health GPS* Program requirements.

If a *My Health GPS* entity reaches their maximum capacity to serve beneficiaries and receives additional requests to enroll beneficiaries, the entity must notify DHCF within one (1) business day with the beneficiary's request for DHCF to reassign the beneficiary to another available *My Health GPS* entity.





Staffing Changes

The *My Health GPS* Entity shall notify DHCF within three (3) business days of any staff changes.

VI. Beneficiary Eligibility

A. Eligible Criteria

- a) Beneficiaries that are eligible to participate in the *My Health GPS* Program must be a DC Medicaid beneficiary.
- b) Eligible beneficiaries must have a minimum of three (3) of the following qualifying chronic conditions:
 - 1. Asthma/COPD
 - 2. Body Mass Index > than thirty-five (35)
 - 3. Cerebrovascular Disease
 - 4. Chronic Renal Failure indicated by dialysis treatment
 - 5. Diabetes
 - 6. Cardiac Dysrhythmias
 - 7. Congestive Heart Failure
 - 8. Myocardial Infarction
 - 9. Pulmonary Heart Disease
 - 10. Hepatitis
 - 11. Human Immunodeficiency Virus
 - 12. Hyperlipidemia
 - 13. Hypertension
 - 14. Malignancies
 - 15. Depression
 - 16. Behavior Disorders
 - 17. Personality Disorders
 - 18. Paralysis
 - 19. Peripheral Atherosclerosis
 - 20. Sickle Cell Anemia
 - 21. Substance Use Disorder

B. Managed Care Organizations (MCO)

The *My Health GPS* Program is available for DC Medicaid beneficiaries that receive services through the Fee for Service (FFS) or Managed Care programs. A beneficiary may be concurrently enrolled in a Managed Care Organization (MCO) and the *My Health GPS* Program, as long as, they are not simultaneously enrolled in the MCO Care Management Program. The *My Health GPS* Providers and the MCOs are partners in the care of shared beneficiaries and should coordinate to ensure the best results for the beneficiaries. To effectively coordinate care for beneficiaries enrolled in an MCO; each *My Health GPS* entity and MCO must enter into a Memorandum of Agreement (MOA). The MOA shall set forth the division of roles and responsibilities between the MCO and the *My Health GPS* entity. The MOA shall also include the monitoring plan and service provisions as prescribed in the Patient Centered Medical Home (PCMH) recognition standards. Each MCO must have a *My Health*





GPS liaison that will work directly with the *My Health GPS* providers to coordinate and avoid unintended duplication of services.

C. Exclusionary Programs

One goal of the *My Health GPS* program is the reduction in healthcare costs. There are Medicaid Programs that cannot be provided at the same time as the *My Health GPS* Program because they are comparable services. These include but are not limited to:

- a) Home and Community-Based Services (HCBS) Waiver for the Elderly and Individuals with Physical Disabilities;
- b) HCBS Waiver for Persons with Intellectual and Developmental Disabilities;
- c) Nursing facility;
- d) Intermediate Care Facility for Individuals with Intellectual Disabilities;
- e) Dual Eligible Special Needs Plan;
- f) Simultaneous enrollment in *My DC Health Home* and the *My Health GPS* program.
 - 1. The beneficiary may choose to enroll in either program but may not be concurrently enrolled in both programs
- g) Other Medicaid status that would make the individual ineligible to receive *My Health GPS* Program includes:
 - 1. No Medicaid eligibility;
 - 2. Qualified Medicare Benefit (QMB); and
 - 3. Incarcerated;

A list of exclusionary Medicaid codes has been provided. (See Appendix A). A beneficiary with any exclusionary Medicaid code is ineligible to participate or be reimbursed for the *My Health GPS* program. An updated list will be shared with providers and MCPs whenever updated by DHCF.

VII. Beneficiary Attribution and Assignment

Attribution is a process that is conducted once a year whereby DHCF reviews Medicaid claims submitted within the previous 12 months and identifies beneficiaries meeting the eligibility criteria for the *My Health GPS* Program. DHCF also assigns a *My Health GPS* Entity for each beneficiary, based on the set of rules described below and provides the beneficiary information to that assigned Entity





D. Maintaining Existing Relationships

- a) An eligible beneficiary will be assigned to the *My Health GPS* entity that currently provides the beneficiary's primary care services or to the *My Health GPS* entity that is part of a corporate entity that currently provides the beneficiary's primary care services
- b) If a beneficiary has more than one (1) current primary provider, the assignment will be made in accordance with the following process:
 - 1) The beneficiary shall be assigned to the *My Health GPS* entity seen most frequently during the review period; or
 - 2) If an eligible beneficiary has seen multiple *My Health GPS* entities with equal frequency during the review period, the beneficiary shall be assigned to the entity seen most recently during the review period.

E. Beneficiaries without Provider Association

Fee-for Service (FFS) or MCO participants that do not have an association with any of the *My Health GPS* entities during the last 12-month Medicaid claims review period are considered beneficiaries without a provider association.

- a) **MCO Participants** - Refers to the beneficiaries that are actively enrolled in an MCO. DHCF will send the *My Health GPS* MCO Liaison a list of the eligible beneficiaries. The Liaison will provide DHCF at least two *My Health GPS* entity placement recommendations for each of the identified beneficiaries
- b) **FFS Beneficiaries** - Refers to the beneficiaries that are actively enrolled in the Medicaid FFS Program. These beneficiaries are assigned based on the following criteria:
 - 1) Geographic proximity of the beneficiary to the *My Health GPS* entity;
 - 2) *My Health GPS* Entity capacity to serve additional beneficiaries; and
 - 3) *My Health GPS* Entity's specialty with select chronic conditions and populations.

Once the attribution process is completed, MHGPS providers will be notified.

DHCF provides a *My Health GPS* report to Providers and MCPs that identifies all the DHCF-attributed *My Health GPS* beneficiaries to the respective providers. This report outlines the beneficiary's attribution date, *My Health GPS* status and other useful information. *My Health GPS* providers should reconcile their list to ensure that their internal list matches DHCF's list. Discrepancies should be resolved by submitting the appropriate documentation and forms (opt-out, withdrawal, provider change, and disenrollment) to DHCF. The newly attributed beneficiaries are loaded onto this report once a year.





F. Referrals

DHCF will accept beneficiary referrals to the *My Health GPS* program from all health care providers.

The referral is completed by submitting a written request, using the *My Health GPS* Referral Form (See Appendix B). The *My Health GPS* Referral Form must be completed in its entirety.

The form must include:

- a) The name and Medicaid ID number of the beneficiary;
- b) The name of the entity making the referral;
- c) Evidence that a provider has submitted claims for the beneficiary identifying three or more qualifying chronic conditions (TCN); and
- d) Date of the claim submission that supports the diagnosis outlined above in “c”

This documentation must be sent securely to the DHCF identified email account. Once received, DHCF will render a decision within 30 days of receipt of the referral and notify the beneficiary and the *My Health GPS* entity of the decision in writing. DHCF will notify the beneficiary in writing about the referral, with an explanation of the *My Health GPS* benefit and the contact information of the *My Health GPS* entity to which they have been assigned. If a beneficiary is referred by an entity that is not a My Health GPS provider, the attribution and assignment process will be used to determine which *My Health GPS* entity will be assigned.

G. Stratification by Acuity

DHCF uses the Chronic Illness and Disability Payment System (CDPS) to determine the acuity level for beneficiaries in the *My Health GPS* program. CDPS is a nationally-recognized risk adjustment tool that is tailored for Medicaid programs. DHCF also reserves the right to use other criteria and/tools that would assist in determining the acuity levels.

The members (beneficiaries) are stratified into two categories, Low Acuity and High Acuity. The beneficiary’s acuity level is fixed for a year except when a re-determination request changes a beneficiary’s acuity level. DHCF will recalculate the acuity levels annually and provide the *My Health GPS* provider a 30-day notice of any acuity change. Prior to 2019, the acuity levels were assigned to a billing code related to specific per member per month reimbursement rates. However, since 2019, MHGPS has transitioned to a per member per quarter rate that is not related to the assigned acuity level. The acuity levels remain as an





indicator for MHGPS entities to determine appropriate engagement with a beneficiary during each billing quarter.

The acuity level codes are:

- Group One (1) Low Acuity - T2022
- Group Two (2) High Acuity - T2023

H. Acuity Re-determination

My Health GPS providers may request an acuity re-determination by DHCF of any beneficiary whose health status changes significantly. If re-determination is requested, the *My Health GPS* provider will be required to submit clinical documentation to DHCF on the approved template (*see Appendix C*) to demonstrate the significant improvement or decline of the beneficiary's health status. The acuity level re-determination can be to a higher or lower acuity. The documentation must include:

- a) Name and Medicaid ID number of the beneficiary;
- b) Name of the *My Health GPS* entity making the request;
- c) Current acuity level and the desired acuity level;
- d) Evidence that supports the request for acuity change;
- e) Summary of the clinical changes that compel an acuity re-determination; and
- f) Entities anticipated plan with acuity change.

This documentation must be sent securely to DHCF's identified email account. Upon receipt of the clinical documentation, DHCF will determine the beneficiary's acuity level. If the *My Health GPS* provider submits the re-determination by the 20th of the month and a change has been determined, the new acuity will become effective the next month. If the request is received after the 20th of the month and a change is indicated, the acuity will be effective the month following the next month. DHCF will provide the *My Health GPS* entity written notification of the determination.

VIII. Beneficiary Participation Status

I. Beneficiary Enrollment

A beneficiary that is attributed and assigned to a provider is not automatically enrolled into the *My Health GPS* program. Enrollment begins after the *My Health GPS* Provider completes the following:

- a) Obtains written consent from the beneficiary to participate in the program;
- b) Completes the initial assessment and care plan;
- c) Submits the initial assessment service for payment; and





- d) Service claim is paid by DHCF.

Enrollment documentation includes:

- a) A signed *My Health GPS* consent form (Appendix E);
- b) A completed in-person biopsychosocial (BPS) needs assessment; and
- c) An interim care-plan.
 - 1) A Care plan is a living document therefore the available information at the time of the assessment should be used at this stage. The subsequent visits with the *My Health GPS* provider will yield more information and the care plan can be updated to be more comprehensive.
 - 2) *My Health GPS* Provider will give the beneficiary a copy of their care plan that outlines the provider's and the beneficiary's responsibility.

An enrolled beneficiary will continue to be eligible to receive *My Health GPS* services unless one of the following occurs:

- a) The beneficiary withdraws consent to participate in the *My Health GPS program*;
- b) The beneficiary is no longer eligible for DC Medicaid;
 - 1) The beneficiary no longer meets the criteria for eligibility in the *My Health GPS program*; or
 - 2) The beneficiary enrolls in another DC Medicaid specialty program that would otherwise exclude eligibility for participation in the *My Health GPS* program (see Beneficiary Eligibility).

J. Beneficiary Consent to Participate in *My Health GPS* Program

When a beneficiary elects to participate in the *My Health GPS* program the beneficiary must sign the *My Health GPS* Consent Form (See Appendix D). A copy of the beneficiary's signed consent form must be provided to the beneficiary as part of the beneficiary's official record.

K. Change of *My Health GPS* Provider

Once enrolled in the *My Health GPS* Program, a beneficiary may elect to receive services from another *My Health GPS* provider, at any time. Likewise, *My Health GPS* providers may determine a beneficiary would be better served by another *My Health GPS*

Interim Care Plan

- (1) Conduct an in-person needs assessment;
- (2) Enter available clinical information and information gathered at the BPS needs assessment into the person-centered plan of care which shall include individualized goals; and
- (3) Retain documentation demonstrating the delivery of each of the activities described in (1) and (2) above.





provider due to capacity limits, limitations in integrating care, or other barriers to integrated care. In this case, the *My Health GPS* provider (transferring provider) must coordinate with the newly identified *My Health GPS* provider (receiving provider) to ensure they are able to accept the beneficiary. Also, attempts should be made to include the beneficiary in this change. All coordination with the *My Health GPS* provider and beneficiary should be documented in the EHR. In either circumstance, changing providers may be an appropriate pathway for the beneficiary. DHCF, at its discretion, may approve or deny a request to change providers. A request to change a *My Health GPS* provider can be accomplished by submitting a Provider Change Form securely to the DHCF identified platform (See Appendix E). The request can be made by the beneficiary, the *My Health GPS* provider, or the Managed Care Organization (MCO).

For requests received on or before the 20th of the current month, the Provider Change request shall be effective on the first day of the following month. If a request is received on or after the 21st of the current month, the Provider Change request shall be effective the first day of the second month. The beneficiary's care and needs continue to remain with the transferring provider until the effective date of the provider change.

DHCF will notify the beneficiary, the transferring provider, and the receiving provider in writing regarding service start and end dates. It is expected that the transferring *My Health GPS* provider will facilitate the transfer by sharing pertinent patient information, such as the care plan and assessment with the receiving *My Health GPS* provider. The new provider shall complete a consent form with the beneficiary.

L. Withdrawal from the Program

A withdrawal for beneficiaries occurs under the following circumstances:

- a) An enrolled beneficiary may decide to end their participation in the *My Health GPS* Program at any time. In this circumstance, the beneficiary can be withdrawn by three options.
 - 1) The beneficiary, must submit the *My Health GPS* Withdrawal Form (See Appendix F) securely to the DHCF identified email account;
 - 2) The *My Health GPS* Provider will complete the Withdrawal Form (See Appendix F) for their records and complete the designated DHCF disposition form. The disposition should be submitted securely to the DHCF identified platform. The *My Health GPS* provider will discuss with the beneficiary their options of re-enrollment, into the *My Health GPS* program; or
 - 3) The MCO can submit the Withdrawal Form securely on behalf of the beneficiary through the identified email account The MCP will discuss with the beneficiary their options of re-enrollment, into the *My Health GPS* program. platform.
- b) If there are no *My Health GPS* claims submitted for three (3) consecutive quarters (9 months) and an internal review indicates that the beneficiary is no longer actively participating in the program;





If the beneficiary requests a reconsideration, it must be submitted in writing, by mail, fax, or in person to DHCF within 30 calendar days of the date of the notice of withdrawal. The request should be addressed to the attention of:

My Health GPS Clinical Care Specialist

441 4th Street, NW Suite 900 South

Washington, DC 20001

Or

Fax number: 202-772-5686

Or

Email: MyHGPS@dc.gov

The request for reconsideration must include information that outlines the reason(s) why the decision to withdraw should not be upheld.

M. Graduated

Any enrolled beneficiary that has met their person-centered goals and does not have updated goals to add on their care plan will be considered graduated. The *My Health GPS* provider will meet with the beneficiary to discuss a transition plan. Additionally, the *My Health GPS* provider will discuss the option of re-enrollment at any time if the beneficiary continues to meet the *My Health GPS* program eligibility criteria.

My Health GPS Provider's Responsibility to Notify Managed Care Plans of Status Change

My Health GPS Providers shall ensure that Managed Care Plans are notified appropriately of all status changes to assigned and enrolled beneficiaries that are assigned to an MCP.

N. Beneficiary Disenrollment

DHCF shall disenroll any previous eligible *My Health GPS* beneficiary that no longer meets the eligibility requirements.

DHCF will issue a written notice to the beneficiary, at least 30 days prior to the effective date of the intended disenrollment to allow for the beneficiary to engage or reengage in the *My Health GPS* Program. The notice will contain:

- 1) Statement of disenrollment;
- 2) Explanation of the reason to disenroll;
- 3) Citations to the laws and rules to support the action;
- 4) The beneficiary's right to request a reconsideration of the disenrollment;
- 5) Timeframe to complete the procedures;
- 6) Fair Hearing process; and





7) Reconsideration process;

O. Decision not to Enroll in the Program (Opt-Out)

A beneficiary that is attributed and assigned to the *My Health GPS* program may elect not to participate. Should a beneficiary choose not to participate, the beneficiary may opt-out of the *My Health GPS* Program. The beneficiary's Medicaid coverage will not be affected based on their decision to enroll or not enroll in the *My Health GPS* Program. The beneficiary may opt-out via one of the following ways:

- a) The beneficiary or beneficiary's representative can complete the Opt-Out Request form at <https://dhcf.dc.gov/> and mail the form to the *My Health GPS* provider or DHCF (See Appendix H)

When DHCF receives the Opt-Out Request Form from the beneficiary or beneficiary's representative, DHCF will notify the assigned *My Health GPS* provider and remove the beneficiary from the list of eligible participants.

- b) The *My Health GPS* provider may complete the Opt-Out Form on behalf of the beneficiary and submit to the secure DHCF identified platform. When a beneficiary decides to opt-out of the program, the *My Health GPS* provider will discuss the option of re-enrollment as long as the beneficiary continues to meet the *My Health GPS* program eligibility criteria. DHCF will also notify the beneficiary, in writing, that the opt-out request has been received. The letter will include their right to re-enroll, alternative program resources and other programmatic information.

IX. Delivery of Services

All the *My Health GPS* services shall be delivered in accordance with best practice protocols developed by the Nurse Care Manager or practitioner with comparable qualifications, as approved by DHCF. Each *My Health GPS* entity shall ensure that enrolled beneficiaries are not receiving duplicate services through any other Medicaid-funded program. All services and attempts of services must be documented in the *My Health GPS* entity's EHR. The services must be provided based on the needs of the beneficiary and be reflective of the person-centered care plan that is developed with the beneficiary.

The *My Health GPS* Program uses billing modifiers to identify the Health Home services that are provided. *My Health GPS* Program allows for telemedicine engagement for non- in person services. Providers should add the appropriate modifier (GT) to all claims that use telemedicine to engage the beneficiary. Transmittals for guidance regarding telemedicine encounters can be found on DHCF's website: [Telemedicine | dhcf](#)

P. Beneficiary Outreach

Each *My Health GPS* provider receives an attributed and assigned list of eligible beneficiaries for outreach. The timeframe of this outreach is as follows:





- a) Once the *My Health GPS* Entity enrolls in the Program; the *My Health GPS* provider shall conduct outreach to all beneficiaries initially assigned by the end of the second quarter; then
- b) Outreach shall be conducted by the *My Health GPS* provider no later than the end of the second quarter for subsequent beneficiary assignments.

The outreach should be documented in the Electronic or Centralized Health Record as follows:

- a) Date and time the outreach was performed;
- b) Identification of the *My Health GPS* provider staff who performed the outreach;
- c) Description of the setting the outreach was performed; and
- d) Description of the outreach including the mode of communication.
- e) Outcome of the outreach

Outreach Collaborative Communication

Beginning in 2026, Managed Care Plans will outreach beneficiaries on the assigned list. The Managed Care Plan will notify DHCF of any beneficiaries that consent to Case Management through an approved DHCF process.

If the Managed Care Plan determines that the beneficiary will be a better fit for the *My Health GPS* program, they will coordinate with the appropriate *My Health GPS* provider.

The beneficiary will remain assigned to the *My Health GPS* program until the provider completes outreach. If the beneficiary consents to the *My Health GPS* program, the provider will notify the respective Managed Care Plan so that they can be disenrolled from case management.

Q. Re-assignment

The *My Health GPS* providers are required to document all attempts to outreach for the attributed beneficiaries in their EHR. If the provider has made reasonable attempts to engage the beneficiary in care, and the beneficiary has not enrolled into the *My Health GPS* program after nine (9) months, the provider will notify DHCF. Upon DHCF's notification, the Department may reassign the beneficiary to another *My Health GPS* entity. If reassignment occurs, DHCF will send written notice to the beneficiary and both *My Health GPS* providers.

R. Documentation Requirements

Each *My Health GPS* provider shall document all program services and activities provided in each beneficiary's EHR. Each claim for a *My Health GPS* service shall meet the requirements outlined in DCMR under Chapter 102 of Title 29 DCMR §10206 and shall be documented in accordance with DCMR under Chapter 102 of Title 29 DCMR § 10207.18 to be reimbursed. The supported documentation shall be supported by the following:

- a) A detailed description of each specific service provided, with sufficient documentation to demonstrate that each service was delivered in compliance with the requirements outlined in the under Chapter 102 of Title 29 DCMR § 10206;





- b) The date and time the service(s) were rendered;
- c) The *My Health GPS* provider staff member who provided the services;
- d) The setting in which the service(s) were rendered;
- e) The beneficiary's person-centered plan of care provisions related to the service(s) provided; and
- f) Documentation of any further action required for the beneficiary's well-being as a result of the service(s) provided.

A. My Health GPS Services

The *My Health GPS* services are:

- 1) Comprehensive Care Management
- 2) Care Coordination
- 3) Health Promotion
- 4) Comprehensive Transitional Care
- 5) Individual and Family Support Services
- 6) Referral to Community and Social Support Services

Comprehensive Care Management consists of the creation, documentation, execution and maintenance of a person-centered plan of care. This service correlates with the U1 and U8 billing modifiers. Activities included in the delivery of Comprehensive Care Management include, but are not limited to, the following:

- a) Conducting a comprehensive biopsychosocial (BPS) needs assessment to collect behavioral, primary, acute and long-term care information from all health and social service providers appropriate for a beneficiary, including providers specific to pediatric beneficiaries, to inform development of the person-centered plan of care. The components of the BPS are:

- 1) Health Status

Examples: Pharmacy, DME, specialists, newly diagnosed, ADLs, clinical history including medications, visual and hearing needs, provider enrollment;

- 2) Cultural Needs

Examples: Race and ethnicity, health disparities, religious barriers to treatments, linguistic needs;

- 3) Educational Needs

Examples: Knowledge about condition, health literacy, healthy behaviors (e.g., nutrition, physical activity, quit tobacco, alcohol use/abuse), preventive care strategies;

- 4) ED/IP Admissions

Example: Frequent use of these services;

- 5) Behavioral Health Needs

Examples: Multiple service needs, cognitive functioning, multiple medications, behavioral health diagnosis;

- 6) Provider Access Issues





Examples: Difficulty with transportation, no medical home;

7) Psychosocial Issues

Examples: Homelessness, school absenteeism, utilities, abuse, crisis management, employment, available benefits and resources;

8) Patient-Centered

Examples: Individual involvement, life planning activities, self-management capabilities;

- b) Developing a person-centered plan of care that reflects the beneficiary's unique cultural needs and is developed in a language or literacy level that the beneficiary can understand, which is documented and maintained in the *My Health GPS* provider's certified EHR system and includes the following six components:
 - (1) A list of the beneficiary's chronic conditions;
 - (2) Issues identified during the comprehensive BPS needs assessment described in (a);
 - (3) Identification of the beneficiary's strengths;
 - (4) Individualized goals that address the beneficiary's chronic conditions and the issues identified during the assessment;
 - (5) Identification of interventions needed to support the beneficiary in meeting the individualized goals; and
 - (6) A plan to review the beneficiary's progress toward the individualized goals at set intervals and to revise the person-centered plan of care as appropriate;
- c) Reassessment and updating the person-centered plan of care in the *My Health GPS* provider's certified EHR system as follows:
 - (1) Every twelve (12) months (Annual update requirement U8);
 - (2) Each time the beneficiary has a significant change in health condition (U1); and
 - (3) Within fifteen (15) days of discharge each time the beneficiary has an unplanned inpatient stay (U1); and
- d) Monitoring the beneficiary's health status and documenting the beneficiary's progress toward the goals contained in the person-centered plan of care, including amending the plan of care, as needed.

Components of the Person-Centered Care Plan

- (1) A list of the beneficiary's chronic conditions;
- (2) Issues identified during the comprehensive biopsychosocial needs assessment;
- (3) Identification of the beneficiary's strengths;
- (4) Individualized goals that address the beneficiary's chronic conditions and the issues identified during the assessment;
- (5) Identification of interventions needed to support the beneficiary in meeting the individualized goals; and
- (6) A plan to review the beneficiary's progress toward the individualized goals at set intervals and to revise the person-centered plan of care as appropriate;





Care Coordination shall consist of implementation of the person-centered plan of care through appropriate linkages, referrals, and coordination with needed services and supports. This service correlates with the U2 billing modifier. Care Coordination services include, but are not limited to, the following:

- a) Scheduling appointments and providing telephonic appointment reminders;
- b) Assisting the beneficiary with navigating health and social services systems, including behavioral health and housing supports as needed;
- c) Providing community-based outreach and follow-up, including face-to-face contact with beneficiaries in settings in which they reside, which may include shelters, the streets or other locations for homeless beneficiaries;
- d) Providing outreach and follow-up through remote means to beneficiaries who do not require in-person contact;
- e) Ensuring that all regular screenings are conducted through coordination with primary care or other appropriate providers;
- f) Ensuring medication reconciliation has been completed;
- g) Assisting with transportation to routine and urgent care appointments;
- h) Assisting with transportation for health-related activities;
- i) Assisting with completion of requests for durable medical equipment;
- j) Obtaining health records and consultation reports from other providers;
- k) Participating in hospital and emergency department transitions of care;
- l) Coordinating with Fire and Emergency Medical Services and DHCF initiatives to promote appropriate utilization of emergency medical and transport services;
- m) Facilitating access to urgent care appointments and ensuring appropriate follow-up care;
- n) Ensuring that the beneficiary is connected to and maintains eligibility for any public benefits to which the beneficiary may be entitled, including Medicaid; and
- o) Providing support to children transitioning from pediatric practice to an adult practice.

Health Promotion shall consist of the provision of health education to the beneficiary, as well as family members or other caregivers when appropriate, that is specific to the beneficiary's chronic conditions and needs as identified in the person-centered plan of care. This service correlates with the U3 modifier. Health Promotion services include, but are not limited to, the following:

- a) Assisting the beneficiary in developing a self-management plan to promote health and wellness, including activities such as substance abuse prevention, smoking prevention or cessation, and nutrition counseling;
- b) Connecting the beneficiary with peer or recovery supports;
- c) Providing support to improve the beneficiary's social network;
- d) Educating the beneficiary about accessing care in appropriate settings, including appropriate utilization of the 911 system;
- e) Assessing the beneficiary's understanding of his or her health conditions and motivation to engage in self-management;
- f) 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; and
- g) Ensuring that health promotion activities align with the beneficiary's stated health and social goals.





Comprehensive Transitional Care shall consist of the planned coordination of transitions between healthcare providers and settings in order to reduce emergency department and inpatient admissions, readmissions and length of stay. This service correlates with the U4 modifier. Comprehensive Transitional Care services shall include, but are not limited to, the following:

- a) Conducting outreach to the beneficiary prior to discharge or within twenty-four (24) hours after discharge to support transitions from inpatient to other care settings, including the following activities:
 - (1) Reviewing the discharge summary and instructions;
 - (2) Ensuring that medication reconciliation has been completed;
 - (3) Ensuring that follow-up appointments and tests are scheduled and coordinated;
 - (4) Assessing the patient's risk status for readmission or other failure to obtain appropriate community-based care;
 - (5) Arranging for follow-up care, if indicated in the discharge plan;
 - (6) Planning for appropriate clinical care post-discharge, including home health services or other necessary skilled care;
 - (7) Planning for appropriate housing support services post-discharge, including facilitating linkages to temporary or permanent housing
 - (8) Arranging transportation for transitional care and follow-up appointments as needed; and
 - (9) Scheduling appointments for the beneficiary with a primary care provider or appropriate specialist(s) within one (1) week of discharge.

Individual and Family Support Services shall consist of activities that assist the beneficiary and his or her support network (including family members and authorized representatives) in identifying and meeting the beneficiary's biopsychosocial needs and accessing necessary resources as identified in the person-centered plan of care. This service correlates with the U5 modifier. Individual and Family Support Services include, but are not limited to, the following:

- a) Facilitating beneficiary access to the following resources:
 - 1) Medical transportation services;
 - 2) Language interpretation services;
 - 3) Housing assistance services; and
 - 4) Any other social services needed by the beneficiary;
- b) Educating the beneficiary in self-management of his or her chronic conditions;
- c) Providing opportunities for family members and authorized representatives to participate in assessment activities and development of the person-centered plan of care;
- d) Ensuring that all *My Health GPS* services are delivered in a manner that is culturally and linguistically appropriate;
- e) Assisting the beneficiary in establishing and maintaining a network of natural supports;
- f) Promoting the beneficiary's personal independence;
- g) Including the beneficiary's family members and authorized representatives in quality improvement processes, including administering surveys to capture their experience with all *My Health GPS* services;





- h) Providing beneficiaries 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; and
 - 1) Developing family support materials and services, including creating family support groups where appropriate.

Referral to Community and Social Support Services shall consist of the process of connecting beneficiaries to resources to help them overcome access or service barriers, increase self-management skills, and achieve overall health, as identified in the person-centered plan of care, and ensuring that the referral is completed. This service correlates with the U6 modifier. Referrals to community and social support services may include but are not limited to:

- a) Wellness programs, including but not limited to smoking cessation, fitness, and weight loss programs;
- b) Support groups specific to the beneficiary's chronic condition(s);
- c) Substance abuse treatment services, including support groups, recovery coaches, and twelve (12)-step programs;
- d) Housing resources, including tenancy sustaining services;
- e) Social integration services, including psychiatric rehabilitation and peer support or consumer-run programs to foster recovery and community re-integration;
- f) Financial assistance, such as Temporary Assistance for Needy Families or Social Security;
- g) Supplemental Nutrition Assistance Program;
- h) Employment and educational programs or training;
- i) Legal assistance resources;
- j) Faith-based organizations; and
- k) Child care

Reimbursement

The appropriate billing codes and modifiers must be used to receive payment for any *My Health GPS* service. See chart below:

<i>My Health GPS Billing Codes</i>	Acuity 1 Case Management	Acuity 2 Case Management
U1- Comprehensive care management post hospitalization and significant events	T2022 – U1	T2023 – U1
U2 - Care coordination	T2022 – U2	T2023 – U2
U3 - Health promotion	T2022 – U3	T2023 – U3
U4 - Comprehensive transitional care/follow-up	T2022 – U4	T2023 – U4





U5 - Patient & family support	T2022 – U5	T2023 – U5
U6 - Referral to community & social support services	T2022 – U6	T2023 – U6
U8- New and Annual Care Plan development	T2022- U8	T2023- U8
GT- Telemedicine- This modifier must be added as a second modifier to each applicable claim.		

To receive the first PMPQ rate payment for a beneficiary, a *My Health GPS* provider shall:

- Verify the prospective enrollee meets the eligibility requirements for the *My Health GPS* program;
- Inform the beneficiary about available *My Health GPS* program services;
- Obtain the beneficiary's informed consent to receive *My Health GPS* Program services in writing; and
- Complete the following components of the person-centered plan of care in accordance with the standards for Comprehensive Care Management.
 - Conduct an in-person BPS needs assessment
 - Enter available clinical information and information gathered at the need- assessment into the person-centered plan of care which shall include individualized goals
 - Retain documentation in the EHR, demonstrating the delivery of each of the activities described in (1) and (2) above.
 - Submit claim to DHCF for the Care Management service provided (Modifier U8)
 - Ensure the claim is paid. If this claim is not paid all subsequent *My Health GPS* service claims will be denied until this claim is resolved (paid)

To receive a subsequent PMPQ rate payments for a beneficiary, a *My Health GPS* provider shall complete:

- At least one (1) *My Health GPS* program service to the beneficiary within the calendar quarter as follows:
 - Verify the enrolled beneficiary meets the eligibility requirements for the *My Health GPS* program prior to service delivery;
 - The service(s) provided during the quarter may be delivered face to face or remotely; or
 - Review and revise the person-centered plan of care (U1), as needed
 - Provide a copy of the revised plan of care to the beneficiary
 - Document these activities in the beneficiary's EHR
- Complete an annual in-person BPS assessment and care plan update **every 12 months**. If this is not completed and coded properly, subsequent payments will be denied. The proper modifier for this service is U8

Care Plan Cycle		
Assessment/Care Plan Modifier Usage on an Annual Cycle	U8 Usage Care Plan Rate (\$364.95)	U1 Usage Acuity-Based rate \$304.98
New Beneficiary (Month 1)	X	
Annual Care Plan (Month 12 and annually thereafter for continued payment)	X	
Post Hospitalization (Months 2-12)		X





Health status changes (Months 2-12)		X
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The *My Health GPS* Program reimburses for the initial and annual care plan PMPQ rate once every 12 months for each beneficiary. Regardless of the provider; once a beneficiary has a paid claim for a U8 another U8 will not be authorized to be paid again for another 12 months. The beneficiary changing providers, withdrawing and re-enrolling does not reset the clock for the initial and annual care plan payment (U8). This information is important to communicate during the warm hand off and coordination from one *My Health GPS* provider to another. When there is a need to complete an assessment and care plan update prior to the annual assessment and care plan update(U8), the providers may use the U1 modifier to capture the service and bill.

Example 1:

A beneficiary enrolls in the program in April 2019 and completes the initial assessment and care plan (Modifier U8). The next annual assessment and care plan update will be due within the same quarter in 2020 (Modifier U8). Any other care plans done within that year would use the modifier U1.

Example 2:

A beneficiary enrolls in the program in April 2019 and completes the initial assessment and care plan (Modifier U8) with Provider A. The beneficiary elects to transfer to Provider B in December 2019. Provider A and B coordinate the transfer, discuss the date of the last initial/annual assessment and care plan. The Provider Change Request Form is completed, and Provider B accepts the beneficiary. DHCF processes the provider change. Provider B completes the assessment and updates the care plan and bills for a T2022 and a U1 modifier. In April 2020, Provider B now completes the annual assessment and care plan update and bills for T2022 and U8.

XI. Quality Reporting Requirements

S. Quality Measures

Quality measurement of the performance and outcomes are necessary to understand the efficacy and the value of the MHGPS program. The primary methods of assessing the *My Health GPS* program will be through the CMS Health Home Core Quality Performance Measures ([Health Home Quality Reporting | Medicaid](#)) These quality measures will be used to evaluate care, providing benchmarks and indicators for program evaluation. The quality measures are calculated based on various data sources such as administrative and hybrid data. DHCF will monitor and review the administrative, or claims, data. The *My Health GPS* entities will be required to report the hybrid measure data to DHCF. Quality measures, in addition to internal performance measures that may be developed by DHCF will be reviewed and assessed to determine areas of improvements for the program.

Hybrid Measure Reporting

Hybrid measure reporting is clinical data that can be used to support claims data and demonstrate a comprehensive picture of the care and services provided to a beneficiary. DHCF will provide a reporting template for the *My Health GPS* providers to utilize for submissions.





T. Annual Program Evaluation

My Health GPS entities may be required to submit an annual program evaluation report by the end of March. The program evaluation should include but not be limited to the following components:

- a) The *My Health GPS* entity's approach to providing services
- b) Barriers to the current delivery of *My Health GPS* services
- c) Interventions unique to the *My Health GPS* entity; and
- d) Strategies to improve future delivery of *My Health GPS* services

If DHCF implements this requirement, the Providers will be given at least a 30-day notice to provide the Program evaluation.

Sentinel Event Reporting

A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm

All *My Health GPS* entities will report all sentinel events within twenty-four (24) hours of occurrence notification or as soon as a determination is made that the occurrence may be a sentinel event. A follow-up, inclusive of a final disposition of the sentinel event shall be sent to DHCF within thirty (30) days of the initial notification to DHCF (Appendix K).

XII. Audits and Reviews

DHCF shall perform audits of *My Health GPS* entities to ensure that Medicaid payments for *My Health GPS* services are consistent with efficiency, economy, quality of care, and made in accordance with Federal and District conditions of payment. DHCF audits of *My Health GPS* entities shall be conducted when necessary to investigate and maintain program integrity. DHCF shall perform audits of claims submitted by *My Health GPS* entities to ensure that the services are adequately documented in accordance with 29 DCMR § 10207.18 and other applicable Federal and District laws. Each *My Health GPS* entity shall facilitate audits and reviews by maintaining the required records and by cooperating with the authorized personnel assigned to perform audits and reviews.

The regulation governing audits and reviews can be found here: DCMR (<http://www.dcregs.dc.gov/>) under Chapter 102 of Title 29 (Public Welfare), Section 10210; or at: <https://dhcf.dc.gov/page/health-home-persons-multiple-chronic-conditions-my-health-gps>.





XIII. Sanctions, Withdrawals, and Terminations

After the completion of an audit, review, or impromptu assessment, DHCF may determine at any time that a *My Health GPS* entity is operating below operational standards of the program. As a result, the *My Health GPS* entity may be requested to submit a Corrective Action Plan (CAP) to resolve any areas DHCF has determined to be partially or not compliant with program standards in accordance with DCMR 29 §102. In addition to operating below operational standards, DHCF may also require a CAP if the *My Health GPS* entity is not compliant with all terms of the DC Medicaid Provider Agreement or does not meet any of the quality standards for the program. DHCF will specify the response time for submitting the proposed CAP. All CAPs are proposed until DHCF approves them. Once approved, DHCF will establish a monitoring plan in collaboration with the *My Health GPS* entity to assess the effectiveness of the approved CAP. Entities determined as non-compliant are subject, but not limited, to the following sanctions:

- a) Denial of further assignments of beneficiaries;
- b) Repayment of service claims rendered during the *My Health GPS* entity's period of non-compliance; or
- c) Termination of the entity's participation in the *My Health GPS* program.

For further information on the proposed CAP, as well as DHCF's approval process, please refer to DCMR 29 §10211. If a *My Health GPS* entity disagrees with DHCF's results of an Audit, Review, or impromptu assessment, the entity may submit documentary evidence of DHCF's findings within thirty (30) days to refute DHCF's findings. DHCF may extend the thirty (30) day period for good cause on a case-by-case basis. DHCF shall issue a final notice to the entity within fifteen (15) days to include a summary of the documentary evidence and the final decision based on the new evidence. *My Health GPS* entities have the right to appeal an unfavorable decision and the sanction(s) imposed by DHCF. An entity may appeal the decision by filing a hearing request with the Office of Administrative Hearings within the timeframe and procedures for filing a hearing request. If the *My Health GPS* entity files a hearing request with the Office of Administrative Hearings within fifteen (15) days of the date of the notice, the effective date of the proposed action shall be stayed until the Office of Administrative Hearings has rendered a final decision.

Entity Withdrawal from *My Health GPS* Program

Notification to DHCF and Beneficiaries

A *My Health GPS* entity may decide to withdraw their participation from the *My Health GPS* program or remove a *My Health GPS* provider from the *My Health GPS* portion of its DC Medicaid Provider Agreement. If a *My Health GPS* entity wishes to withdraw, the entity shall:

- a) Provide ninety (90) days written notice to DHCF of the intended withdrawal from the *My Health GPS* program or the removal of a specific *My Health GPS* provider(site) from the *My Health GPS* portion of the DC Medicaid Provider Agreement.
 - b) Suspend enrolling any new beneficiaries as of the day of notification to DHCF.
- The notice to DHCF should include the following:





- 1) A Comprehensive plan to transfer consenting beneficiaries to an accepting *My Health GPS* provider or entity.
 - 2) Specific timeline of the withdrawal/termination process
 - 3) Comprehensive plan to notify the Managed Care Plans of the withdrawal and status updates of beneficiaries.
 - 4) Plan for retaining a staff member or point of contact to assist beneficiaries for at least 30 (thirty) days post withdrawal.
 - 5) Plan to provide applicable resources to beneficiaries that decline transitioning to another *My Health GPS* provider.
 - 6) If applicable, the plan for the entity to execute a modified *My Health GPS* Agreement if removing a specific *My Health GPS* provider site.
- c) Submit to DHCF a copy of the drafted provider withdrawal notification letter to beneficiaries. DHCF should receive this draft by the 80th day prior to the *My Health GPS* Entity's end date. DHCF will review the drafted letter and provide an approval or request for necessary adjustments to the *My Health GPS* entity within 5 business days. The letter should contain the following:
- 1) Notice of the *My Health GPS* program's termination.
 - 2) Date that the *My Health GPS* entity will be ending their participation in the *My Health GPS* program.
 - 3) The beneficiary's options:
 - i. To change the *My Health GPS* provider
 - ii. Contact DHCF to assist in transferring to another *My Health GPS* Provider
 - 4) Supply a list of the current *My Health GPS* providers in the letter.
 - 5) Reminder that the termination of this program does not affect their Medicaid benefits.
 - 6) Provide the DHCF website for more information on the District's Health Home Programs; <http://dhcf.dc.gov/page/health-homes>.
- d) Issue the DHCF approved letter with at least a 30-day notice to the enrolled beneficiaries.

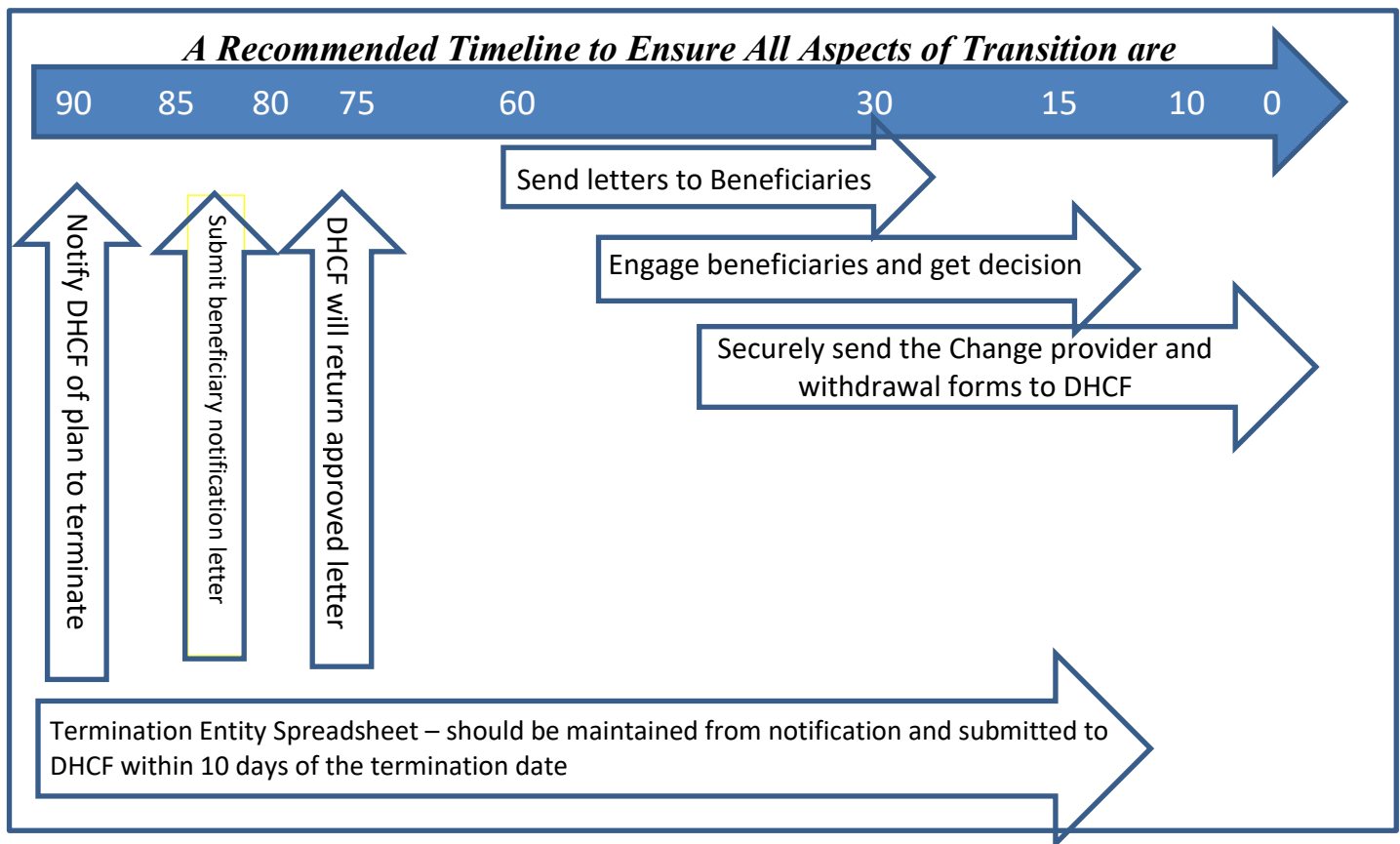
The appropriate *My Health GPS* form shall be completed for each beneficiary that identifies their decision and disposition (Change Provider and Withdrawal form). These forms must be sent to DHCF securely as the beneficiaries make their decision.

- e) Develop and complete a *My Health GPS* Entity Withdrawal/Termination spreadsheet that contains the following elements:
- 1) Medicaid Number
 - 2) Last Name
 - 3) First Name
 - 4) Date Letter sent to the beneficiaries
 - 5) MCO
 - 6) Date MCO notified
 - 7) Beneficiary Decision
 - i. Change provider
 - ii. Withdrawal





- 8) New MHGPS provider
 - i. Coordination complete date
- 9) Care Transition Note completed in HER





XIV. Billing and Reimbursement

U. Claims Submission and Reimbursement

Claims are received by DHCF's Fiscal Agent in one of two media types: paper or electronic. Providers may be reimbursed for three (3) types of *My Health GPS* services:

- a) The Comprehensive Care Management service that encompasses the initial assessment (BPS) and care plan development
- b) Quarterly PMPQ rate;
- c) Annual assessment and care plan update

Before submitting a *My Health GPS* claim, the provider should verify the following:

- a) Medicaid eligibility at the time-of-service delivery;
- b) Ensure the services delivered are documented as outlined in the regulations DCMR Chapter 102 of Title 29 (Public Welfare)

V. Duplicative Billing

Providers may not bill for duplicative or like Medicaid funded services. If there are services that appear to be like services, the Provider must investigate and decide on which Medicaid Program is appropriate to deliver the service and bill accordingly.

W. Denials

The *My Health GPS* Program is based on a PMPQ rate payment methodology. Once a claim is submitted and reimbursed, any additional *My Health GPS* claims submitted for additional encounters within a given quarter will be denied.

My Health GPS providers have two (2) options to report service utilization. They may:

- 1) Submit a claim for every service provided to the beneficiaries; or
- 2) Submit a report to monthly report to DHCF. The template will be provided by DHCF.

Each claim can hold up to four (4) distinct modifiers. If more than one service type (for example U1, U3 and GT) is delivered at the same encounter the provider can include all modifiers on the claim. This process eliminates denials that would have occurred if billed separately. This also gives DHCF the data needed to assess service utilization

X. Compliance Monitoring

An on-site compliance monitoring visit will be conducted with every MHGPS provider at least every three (3) years. DHCF reserves the right to conduct an on-site monitoring visit to every MHGPS provider as often as necessary to ensure compliance with the MHGPS program regulations at 29 DCMR 102. Therefore, selection for an on-site visit should not be construed as punitive action or an indication that the MHGPS provider is not meeting compliance or performance targets.





Glossary

Adverse Event	An injury/harm/unexpected death that occurs while a beneficiary is receiving health care services from a practitioner/provider.
Assigned	Beneficiary has been attributed to a MHGPS provider; has not provided consent; has not had a claim submitted for the first comprehensive care management service.
Beneficiary	An individual deemed eligible for and in receipt of services provided through the District Medicaid program.
Calendar Year	A Twelve (12) month period beginning on January 1 st and ending December 31 st
Corporate Entity	An organization that holds a single Employer Identification Number, as defined in 26 C.F.R. § 301.7701-12.
Disenrolled	Beneficiary is no longer eligible to receive the MHGPS benefit due to no longer meeting the eligibility requirements.
Enrolled	When an eligible Beneficiary has signed the <i>My Health GPS</i> consent, the <i>My Health GPS</i> Provider has completed BPS assessment, and initial care plan, submitted the claim for the service and has received payment for the service.
Face to Face	The engagement with the beneficiary that is a real-time interaction that can be in-person or using technology to communicate and see one another when they are not in the same location e.g. video conferencing,
Fair Hearing	A procedure whereby the District provides an opportunity for a hearing to any person whose claim for assistance is denied consistent with the requirements set forth in 42 CFR 431.200 et.seq.
Federally Qualified Health Center	An organization that meets the definition set forth in Section 1905(l)(2)(B) of the Social Security Act (42 U.S.C.1396d(1)(2)(B)).





Fiscal Year (District)	A twelve (12) month period beginning October 1st and ending September 30th.
Graduated	The member has achieved his/her goals that supported Health Home enrollment and is ready and able to self-manage any post care and services needed.
Hybrid Data	A combination of administrative data (i.e. claims, encounters, and vital records) and clinical data contained in medical records.
Inactive	Based on a review of claims submitted by the provider, the Beneficiary has not received a MHGPS service for 3 consecutive quarters.
<i>My Health GPS</i> Entity	A primary care clinical individual practice, primary care clinical group practice, or Federally Qualified Health Center currently enrolled as a District Medicaid provider that incorporates a <i>My Health GPS</i> provider into its primary care service delivery structure.
<i>My Health GPS</i> Provider	An approved interdisciplinary team that delivers <i>My Health GPS</i> services within a <i>My Health GPS</i> entity.
Opt- Out	The process by which a beneficiary chooses not to participate in the <i>My Health GPS</i> program.
Outreach	Active and progressive attempts at beneficiary engagement, including direct communication (i.e. face-to-face, mail, email, telephone) with the beneficiary or the beneficiary's designated representative.
Reasonable Attempts	Reasonable attempts will be considered at least three (3) or more attempts, made at different times of the day and on different days, as well as a follow-up letter over the nine (9) months.
Receiving Provider	The provider that will become the newly attributed <i>My Health GPS</i> provider for a beneficiary that is transferring to them from another <i>My Health GPS</i> provider. Also considered the accepting provider.
Sentinel Event	Any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient and which is not related to the natural course of the patient's illness.
Termed	Beneficiary is no longer currently Medicaid eligible.
Transferring Provider	The current attributed <i>My Health GPS</i> Provider of a beneficiary that is changing <i>My Health GPS</i> Providers. Also considered the sending provider.
Transition Record	The document containing information regarding a patient's diagnosis and treatment received during an inpatient stay that is





	transmitted to relevant providers following the patient's discharge.
Withdrew	Beneficiary has "enrolled" but no longer wants to participate in the MHGPS program or the beneficiary is in an "inactive" status and case review recommendation is to disenroll.





APPENDIX

- A- Exclusionary Medicaid Codes**
- B- Referral Form**
- C- Acuity Re-determination Template**
- D- Consent Forms**
- E- Provider Change Form**
- F- Withdrawal Form**
- G- Fair Hearing Process**
- H- Opt-out Form**
- I- CMS Health Home Core Quality Measures**
- J- Aggregate Option Form**
- K- Sentinel Event Form**
- L- Service Report**
- M- Billing Manual**
- N- Frequently Asked Question**





APPENDIX A
Exclusionary Medicaid Codes
DHCF Will Share Updated List Directly to MHGPS Providers

010A	420	814X	878
010Q	470	853A	878Q
010S	470Q	853D	913Q
012Q	470Z	853P	943
050A	606	853Q	943Q
050Q	607	853S	953
050S	609	853X	953Q
052Q	618	853Z	130I
070	628	854	150I
113	638	854D	211I
113Q	648	854Q	221I
143	658	854X	222I
143Q	668	858	231I
150L	678	858Q	241I
153	690	873	242I
153Q	780	873A	271I
313	780A	873P	361I
313P	780D	873Q	420I
313Q	780E	873S	470I
313Z	780N	873Z	710I
343	804	874	730I
343Q	804Q	874D	774I
353	814	874Q	774L
353Q	814D	874X	775I





Appendix B

MY HEALTH GPS REFERRAL FORM

For DHCF Only

Date received _____

Determination _____

Determination Date _____

Notification Date _____

DHCF Staff _____

Date _____

Beneficiary Name _____ Beneficiary Address _____

Beneficiary Phone Number _____ Medicaid ID _____ DOB _____

Referring Entity/Agency _____ Staff completing form _____

Three qualifying chronic conditions

Asthma/COPD	Congestive Heart Failure	Hypertension	Peripheral Atherosclerosis
BMI > 35	Myocardial Infarction	Malignancies	Sickle Cell Anemia
Cerebrovascular Disease	Pulmonary Heart Disease	Depression	Substance use Disorder
CRF indicated by dialysis	Hepatitis	Behavioral Disorders	
Diabetes	HIV	Personality Disorders	
Cardiac Dysrhythmias	Hyperlipidemia	Paralysis	

Evidence that a provider has submitted claims for the beneficiary identifying three or more qualifying chronic conditions.

TCN _____ Date _____

TCN _____ Date _____

TCN _____ Date _____

Referring Agency staff name (print)

Referring Agency staff name
(signature)

Date Signed

For DHCF Use Only

Date DHCF received

Determination Date

Notification Date





Appendix C



**MY HEALTH GPS
Acuity Re-determination Request**

For DHCF Only

Date received _____
Determination _____
Determination Date _____
Notification Date _____
DHCF Staff _____
DHCF Staff _____

Date _____

Beneficiary Name _____ Beneficiary Address _____

Beneficiary Phone Number _____ Medicaid ID _____ DOB _____

Requesting Entity/Agency _____ Staff completing form _____

Current Acuity (circle) - HIGHER/LOWER **Requested Acuity (circle) - HIGHER/LOWER**

(1) Evidence that supports the request for acuity change;

(2) Summary of the clinical changes that compel an acuity re-determination:

(3) Entities anticipated plan with acuity change.

Requesting Agency staff name (print)

Requesting Agency staff name
(signature)

Date Signed

----- **For DHCF Use Only** -----

Date DHCF received

Determination Date

Notification Date





Consent Forms

Amharic
Arabic
Burmese
Cantonese
English
Farsi
French
Haitian
Hindi
Hmong
Italian
Japanese
Korean
Mandarin
Polish
Portuguese
Punjabi
Somali
Spanish
Tagalog
Russian
Vietnamese





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እባክዎትን ይህንን ፎርም ከመፈረምዎ በፊት ሁሉንም መረጃ በጥንቃቄ ያንብቡ።
(Amharic)

በ ኮሎምቢያ ዲስትሪክት ሜዲኬድ የሚሰጠው የ ጤናዬ GPS ፕሮግራም። ጤናማ ለመሆን የሚያስፈልግዎትን እንክብካቤ ይሰጥዎታል። የ ጤናዬ GPS ፕሮግራምን መቀላቀል የእርስዎ ምርጫ ነው። ለመቀላቀል የማይፈልጉ ከሆነ፣ የሜዲኬድ አገልግሎትዎን ማግኘት መቀጠል ይችላሉ።

የ ጤናዬ GPS አጋጮች እንዴት አንድ ላይ እንደሚሰሩ

የ ጤናዬ GPS ትልቅ አካል ሆስፒታሎች እና ሌሎች የ ጤና እንክብካቤ አቅቢዎች ለእርስዎ የተሸለ እንክብካቤን እንደሚሰጡ ማረጋገጥ ነው። ፕሮግራሙን የሚቀላቀሉ ከሆነ፣ የጤና መረጃዎች ለእርስዎ እንክብካቤ ከሚሰጡ ሆስፒታሎች እና ጤና እንክብካቤ አቅቢዎች ጋር ሊጋራ ይችላል። ይህም ካለፈው ወይም ወደፊት ከሚገኘው የጤና ታሪክዎ ሊሆን ይችላል።

የግለሻነት መብት

የጤና መረጃዎ የግልዎ ነው። ህግን እስካልተከተለ ድረስ ለማንም አይሰጥም። ሁሉም የማህበረሰብ ጤና እንክብካቤ አቅቢዎች የእርስዎን መረጃ የሚያገኙ ከሆነ ይህንን መረጃ ማግኘት መቻል ያስፈልጋቸዋል። እርስዎ እስካልተሰማሙ ድረስ ወይም ህግ እስካላስገደዳቸው ድረስ መረጃዎትን ለማንም ማጋራት አይችሉም። ይህ የጤና መረጃዎች በኮምፒውተር ላይ ቢሆንም እንኳን እውነት እንደሆነ ይቆያል።

ይህንን ፎርም በመፈረም፣ በ ጤናዬ GPS ላይ ለመሳተፍ እስማማለሁ። በቋሚነት ለመሳተፍ የምስማማ ሲሆን፣ ሀሳቤን ለመቀየር እንደምችል ገብቶኛል።

በዚህ ወረቀት ላይ ያለውን መረጃ አንብቤ የተረዳሁ ሲሆን ጥያቄዎችን ለማንሳትም እድል አግኝቼ ነበር። ተሳትፎዬ በግል ፈቃደኝነት ላይ የተመሰረተ እንደሆነ እና በማንኛውም ሰአት ላይ ለማቋረጥ እንደምችል ይህም ምንም አይነት ምክንያት ሳልሰጥ ማለት ነው፤ ገብቶኛል።

የተሳታፊው ስም (እባክዎትን ይጻፍ)

የልደት ቀን

የተሳታፊ ፊርማ

የዛሬው ቀን

ወላጅ፣ ህጋዊ አሳዳጊ፣ ህጋዊ ተወካይ ፊርማ
(የሚተገበር ከሆነ)

የዛሬው ቀን





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موافقة على المشاركة في برنامج *My Health GPS* Arabic

إن برنامج *My Health GPS* هو برنامج متوفر من قبل برنامج Medicaid لمحافظة كولومبيا. إنه يساعدك على الحصول على العناية التي تحتاج إليها حتى تبقى في حالة صحية جيدة. إن اختيار دخول برنامج *My Health GPS* هو إختيارك الخاص. إذا لم ترغب بالالتحاق بالبرنامج فما زال سوف تحصل على خدماتك تحت برنامج Medicaid.

كيفية تعامل شركاء *My Health GPS* مع بعض

إن الجزء الكبير من اعمال *My Health GPS* هو عبارة عن التأكد من قيام المستشفيات وكذلك اي من الجهات التي توفر خدمات العناية الصحية لك بأعمالها كشركاء حتى يتم العناية بك بشكل أفضل. إذا قمت بالالتحاق بالبرنامج فإن هناك احتمال مشاركة معلومات خاصة بعنايتك الصحية مع المستشفيات والجهات التي توفر لك العناية الصحية. وقد تشمل هذه المعلومات على بيانات ماضية قديمة في سجلك الطبي أو بيانات تتعلق بوضعك الصحي في المستقبل.

الحق على الخصوصية

إن معلوماتك الصحية هي تعتبر معلومات خاصة. لا يمكن إعطائها إلى ناس آخرين إلا إذا راعوا القانون. على كافة الجهات الموفرة لخدمات العناية الصحية أو الخدمات الاجتماعية التي لديها قدرة مراجعة معلوماتك الصحية ملزمة برعاية كل هذه القوانين ويمنع عليها مشاركة المعلومات الخاصة بك إلا مع موافقتك أو إذا نص القانون على السماح لها منح هذه المعلومات إلى أطراف أخرى. وينطبق هذا بغض النظر عن خزن بياناتك الصحية على نظام حاسوبي أو على أوراق.

إنني أعلن مع توقيعي على هذه الاستمارة موافقتي على المشاركة في برنامج *My Health GPS*. إنني اوافق على المشاركة بشكل فعال وأفهم كذلك بأن في يدي حرية تغيير رأيي في هذا الشأن.

لقد قرأت كافة المعلومات الواردة في هذه الوثيقة وفهمتها كما تم اعطاء لي فرصة لطرح الأسئلة بشأنها. كما أنني افهم بأن مشاركتي مبنية على أساس تطوعي وأن بيدي حرية الانسحاب من البرنامج في اي وقت وذلك بدون الكشف عن سبب ذلك

الانسحاب أو تحمل اي مصاريف عليه.

تاريخ الميلاد	إسم المشارك (يرجى الكتابة بحروف واضحة)
تاريخ اليوم	توقيع المشارك





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ကျွန်တော်/ကျွန်မ၏ ကျန်းမာရေး GPS အစီအစဉ်တွင် ပါဝင်ဆောင်ရွက်ရန် သဘောတူညီချက် (Burmese)

**ဤပုံစံပေါ်မှာ ရှိသမျှသော သတင်းအချက်အလက်များအားလုံးကို
လက်မှတ်ထိုးမီကျေးဇူးပြု၍ဖတ်ရှုပါ။**

ကျွန်တော်/ကျွန်မ၏ ကျန်းမာရေး GPS ဆိုသည်မှာ ကိုလံဘီယာ ခရိုင် Medicaid မှ ကမ်းလှမ်းသော အစီအစဉ်တစ်ခု ဖြစ်သည်။ ဒီအစီအစဉ်ဟာ သင်၏ကျန်းမာရေး စောင့်ရှောက်မှုရှိစေ၍ အထောက်အကူ ပြုပါသည်။ ဒီကျန်းမာရေး GPS အစီအစဉ်တွင် ပါဝင်ပူးပေါင်းရန် သင်၏ ရွေးချယ်မှုဖြစ်ပါသည်။ အကယ်၍ သင့်အနေနဲ့ မပါဝင်ကြဘူးဆိုရင်လဲ သင်၏ Medicaid ဝန်ဆောင်မှုများကို ရရှိပါလိမ့်မည်။

ကျွန်တော်/ကျွန်မ၏ ကျန်းမာရေး GPS မိတ်ဖက်သူတွေ ပူးတွဲပြီး ဘယ်လိုဆောင်ရွက်ပါသလဲ။

ကျွန်တော်/ကျွန်မ၏ ကျန်းမာရေး GPS ၏ ကြီးမားသော အစိတ်အပိုင်းတစ်ခုက ဆေးရုံများနှင့် သင့်ကျန်းမာရေးကို စောင့်ရှောက်ပေးသူများအား မိတ်ဖက်သူတွေအဖြစ်သေချာစေပြီး သင့်အားကောင်းကောင်းမွန်မွန် ပြုစု ၍ ပူးတွဲပြီး အလုပ်လုပ်ပေးပါသည်။ အကယ်၍ သင်က ဒီအစီအစဉ်မှာ ပါဝင်မယ်ဆိုရင် သင်၏ကျန်းမာရေး သတင်းအချက်အလက်များအားလုံးကို ဆေးရုံများနှင့် သင့်အားကျန်းမာရေးကို စောင့်ရှောက်မှုပေးသောသူများအားလုံးအား မျှဝေပေးနိုင်ပါသည်။ ဤသတင်းအချက်အလက်ထဲမှာ သင်၏ကျန်းမာရေးမှတ်တမ်းမှာပါရှိသော ယခင်က ကျန်းမာရေး အချက်အလက်ရော၊ သို့မဟုတ် ယခု အချက်အလက်တွေပါ ထည့်သွင်းပါဝင်နိုင်ပါသည်။

ပုဂ္ဂလိက အခွင့်အရေး

သင့်ကျန်းမာရေးအချက်အလက်သည် ပုဂ္ဂလိက (သီးသန့်) ဖြစ်ပါသည်။ တရားဥပဒေအတိုင်း ဆောင်ရွက်ခြင်း မရှိပါက ဤကျန်းမာရေး သတင်းအချက်အလက်တွေကို မည်သူ့ကိုမှ ပေးလို့မရပါ။ ကျန်းမာရေး စောင့်ရှောက်မှုအားလုံး (သို့မဟုတ်) လူမှုအသိုင်းအဝိုင်း ဝန်ဆောင်မှုပေးသူများအားလုံးသည် သင်၏ကျန်းမာရေး အချက်အလက်ဆိုင်ရာ တရားဥပဒေအားလုံးကို လိုက်နာဆောင်ရွက်ရပါမည်။ သူတို့က သင်၏သဘောတူညီမှု မရရှိဘဲ (သို့မဟုတ်) ဥပဒေက ခွင့်မပြုလျှင် သင်၏ကျန်းမာရေး သတင်းအချက်အလက်ကို သူများအား





မျှဝေလိုမရပါ။ သင်၏ကျန်းမာရေးအချက်အလက်က ကွန်ပျူတာစနစ်မှာ ရှိရှိ (သို့မဟုတ်) စာရွက်စာတမ်းပေါ်မှာ ရှိစေကာမူ သူများအား မျှဝေပေးလို မရသည်မှာ မှန်ကန်ပါသည်။

ဤပုံစံကို လက်မှတ်ရေးထိုးခြင်းအားဖြင့် ကျွန်တော်/ကျွန်မ၏ ကျန်းမာရေး GPS တွင် မိမိအနေဖြင့် ပါဝင်ဆောင်ရွက်ရန် သဘောတူပါသည်။ ကျွန်တော်/ကျွန်မက တက်ကြွစွာ ပါဝင်ဆောင်ရွက်ရန် သဘောတူပါလျှက်နှင့် မိမိ၏ စိတ်ဆန်ဒကိုလည်း ပြောင်းလဲစေနိုင်ကြောင်း နားလည်သဘောပေါက်ပါသည်။

ဤစာရွက်စာတမ်းမှာ ပါရှိသော သတင်းအချက်အလက်ကို ဖတ်ရှုပြီး မိမိအား မေးစရာမေးခွန်းများရှိရင်လဲ မေးမြန်းရန်အခွင့်အလမ်းများ ပေးထားကြောင်း နားလည်းသဘောပေါက်ပါသည်။ ကျွန်တော်/ကျွန်မ၏ ပူးပေါင်းပါဝင်မှုသည် မိမိဆန်ဒသဘောအလျောက်သာဖြစ်ပြီး မည်သည့်အချိန်အ ခါတွင်မဆို အကြောင်းပြချက် နှင့် အခကြေးငွေ မပါဘဲ လွတ်လွတ်လပ်လပ် ရုပ်သိမ်းခြင်းရှိကြောင်းကိုလည်း သဘောပေါက်ပါသည်။

_____	_____
ပါဝင်သူ၏အမည်(နာမည်ရေးပါ)	မွေးသက္ကရာဇ်
_____	_____
ပါဝင်သူ၏လက်မှတ်	ယနေ့ရက်စွဲ
_____	_____
မိဘ/အုပ်ထိန်းသူ/ဥပဒေရေးရာကိုယ်စားလှယ် (ရှိလျှင်)	ယနေ့ရက်စွဲ





同意參加我的健康 GPS 計畫
(Cantonese)

Insert
Your Logo
Here

請在簽名之前閱讀本表的所有資訊

我的健康 GPS (My Health GPS) 是一個由哥倫比亞特區醫療補助計畫 (Medicaid) 提供的計畫，可幫助您獲得所需的護理，讓您保持身體健康。是否加入我的健康 GPS 計畫是您自己的選擇。如果您不想加入，您仍然可以獲得您的醫療補助計畫服務。

我的健康 GPS 如何與合作夥伴協作

我的健康 GPS 的很大一部分就是確保，各家醫院和您的任何醫療服務提供者能夠作為合作夥伴協作，一起更好地照護您。如果您加入本計畫，您的健康資訊可能會與照護您的醫院和醫療服務提供者分享。這可能包括您健康記錄中過去或將來的資訊。

隱私權

您的健康資訊是您的私人資訊，不會交給不遵守法律的他人。可以看到您健康資訊的所有醫療服務提供者或社區服務提供者都必須遵守所有這些法律。除非您同意或法律說明可以將資訊提供給其他人，否則他們不能分享您的資訊。即使您的健康資訊已留在電腦系統或紙頁上也是如此。

簽署本表時，我即同意參與我的健康 GPS。我同意積極參與，而且我明白我可以改變主意。

我已閱讀並理解本文件中的資訊，並已有機會提出問題。我明白我的參與純屬自願，我可以隨時自由退出，無需任何理由，也無需支付任何費用。

參與者姓名（請清楚填寫）

出生日期

參與者簽名

今天的日期

家長／監護人／法定代理人簽名
（如適用）

今天的日期





Insert
Your Logo
Here



Consent to Participate in the *My Health GPS* Program (English)

Please read all the information on this form before you sign it.

My Health GPS is a program offered by the District of Columbia Medicaid. It helps you get the care you need to be healthy. It is your choice to join the *My Health GPS* Program. If you do not want to join, you will still get your Medicaid services.

How *My Health GPS* Partners work together

A big part of *My Health GPS* is making sure hospitals and any of your health care providers work as partners to better care for you. If you join the program, your health information may be shared with hospitals and providers that care for you. This could include information from the past or in the future within your health record.

Right to privacy

Your health information is private. It cannot be given to other people unless they follow the law. All health care or community service providers who can see your health information must obey all these laws. They cannot share your information unless you agree, or the law says they can give the information to other people. This is true even if your health information is on a computer system or on paper.

By signing this form, I consent to participate in *My Health GPS*. I agree to actively participate, and I understand that I can change my mind.

I have read and understand the information in this document and was given the chance to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost.

Participant's Name (please print)

Date of Birth

Participant's Signature

Today's Date

☐ Beneficiary consented via telehealth visit with (name of staff) _____ Date _____





Parent/Guardian/ Legal Rep Signature (If Applicable)

Today's Date

Insert
Your Logo
Here

لطفاً قبل از امضا کردن تمامی اطلاعات در این فرم را مطالعه نمایید
(Farsi)



برنامه بهداشتی *My Health GPS* یک برنامه ایست که توسط سازمان خدمات درمانی Medicaid شهرستان کولومبیا تقدیم می شود. این برنامه کمک می کند تا که خدمات درمانی مورد احتیاج برای تندرستی شما را دریافت نمایید. شرکت شما در برنامه *My Health GPS* انتخاب خود شما می باشد. اگر نمی خواهید به این برنامه بپیوستید هنوز هم خدمات درمانی تان را از طرف Medicaid دریافت خواهید کرد.

چگونه شرکای برنامه *My Health GPS* با یکدیگر همکاری کنند
بخش بزرگی از کار برنامه *My Health GPS* اطمینان حاصل شدن از این که بیمارستان ها و همه سازمان های ارائه کننده خدمات درمانی شما به عنوان شرکا با یکدیگر همکاری کنند، تا که خدمات درمانی شما بهبود یابند. اگر وارد این برنامه شوید، احتمال وجود خواهد داشت که اطلاعات خصوصی بهداشتی شما با بیمارستان ها و سازمان های ارائه کننده خدمات درمانی شما توزیع شود. این هم می تواند شامل اطلاعاتی از گذشته یا در آینده در پرونده سلامتی شما باشد.

حق به حریم خصوصی

اطلاعات بهداشتی شما خصوصی می باشد. این اطلاعات نمی تواند به دیگران داده شود مگر اینکه آنها قانون را دنبال کنند. همه ارائه دهندگان خدمات بهداشتی یا ارائه دهندگان خدمات اجتماعی که می توانند اطلاعات بهداشتی شما را ببینند باید از تمام این قوانین پیروی کنند. نمی توانند اطلاعات شما را به اشتراک بگذارند مگر اینکه شما موافقت کنید یا قانون می گوید که می توانند این اطلاعات را به دیگران ارائه دهند. این وضعیت همینطور درست است اگر اطلاعات بهداشتی شما در یک سیستم کامپیوتری یا بر روی کاغذ باشد.

با امضای این فرم، موافقت می نمایم که در برنامه *My Health GPS* شرکت کنم. قبول می کنم که به طور فعال شرکت کنم و همینطور درک می کنم که می توانم نظرم را راجع به شرکت در برنامه تغییر دهم.

اطلاعات در این سند را مطالعه و فهمیده ام، و فرصتی برای پرسیدن سوال ها به من داده شده است. درک می کنم که شرکت داورطلبانه می باشد و این که می توانم در هر زمان از برنامه خارج شوم بدون دادن هیچ دلیلی و بدون مجبور شدن به پرداختن هزینه.

نام شرکت کننده (لطفاً بحرفهای چاپ بنویسید)	تاریخ تولد
امضای شرکت کننده	تاریخ امروز
امضای شرکت کننده / ولی قانونی / نماینده قانونی (اگر موجود باشد)	تاریخ امروز





Insert
Your Logo
Here



**Consentement à participer au programme *My Health GPS*
(French)**

Veuillez lire toutes les informations sur ce formulaire avant de le signer

My Health GPS est un programme offert par le Medicaid du District de Columbia. Cela vous aide à obtenir les soins dont vous avez besoin pour être en bonne santé. C'est votre choix de rejoindre le programme *My Health GPS*. Si vous ne souhaitez pas joindre ce programme, vous recevrez toujours vos services Medicaid.

Comment les partenaires de *My Health GPS* travaillent ensemble ?

Une grande partie de *My Health GPS* veille à ce que les hôpitaux et n'importe quel prestataire de soins et de santé travaillent en tant que partenaires pour mieux vous soigner. Si vous adhérez à ce programme, vos données médicales peuvent être partagées avec les hôpitaux et les prestataires qui vous soignent. Cela pourrait inclure des informations du passé ou de l'avenir dans votre dossier de santé.

Protection des données médicales

Vos données médicales sont privées. Ils ne peuvent être donnés à d'autres personnes que si elles suivent la loi. Tous les prestataires de soins et de santé ou de services communautaires qui ont accès à vos données médicales doivent obéir à toutes ces lois. Ils ne peuvent partager vos informations que si vous êtes d'accord ou que la loi stipule qu'elles peuvent donner l'information à d'autres personnes. Cela s'applique, même si vos données de santé se trouvent sur un système informatique ou sur papier.

En signant ce formulaire, je donne mon consentement à participer à *My Health GPS*. J'accepte de participer activement, et je suis conscient que je peux changer d'avis.

J'ai lu et compris les informations contenues dans ce document et j'ai eu la possibilité de poser des questions. Je comprends que ma participation est volontaire et que je suis libre de me retirer à tout moment, sans donner de raison et sans frais.

Nom du participant (imprimer)

Date de naissance

Signature du participant

La date d'aujourd'hui

Signature du parent / tuteur / représentant légal
(Le cas échéant)

La date d'aujourd'hui





**Konsantman pou Patise nan Pwogram *My Health GPS*
(Haitian Creole)
Tanpri, li tout enfòmasyon ki sou fòm sa a anvan ou siven l.**

My Health GPS se yon pwogram ke Medicaid nan District Columbia ofri. Li ede w jwenn swen ou bezwen pou w ka an sante. Se chwa Ou si w vle antre nan pwogram *My Health GPS* la. Si ou pa vle antre nan pwogram lan, wap toujou jwenn sèvis Medicaid ou yo.

Kòman Patnè *My Health GPS* yo travay ansanm

Yon gwo pati nan *My Health GPS* la se pou fè lopital yo ak nenpòt founisè sante w yo travay an patenaria pou yo ka ba ou pi bon swen. Si ou antre nan pwogram nan, enfòmasyon sou sante w yo kapab pataje ant lopital ak lòt founisè sante kap pran swen w yo. Sa ka enkli enfòmasyon ki nan pase ak nan lavni ki nan dosye sante ou.

Dwa sou lavi prive w

Enfòmasyon sou sante w se bagay ki prive. Yo pa ka bay lòt moun li sof si yo swiv règleman lalwa. Tout founisè sante oswa sèvis kominotè ki ka wè enfòmasyon medikal ou dwe obeyi tout sa lalwa di. Yo pa ka pataje enfòmasyon ou sòf si ou dakò oswa lalwa di pou yo bay lòt moun enfòmasyon an. Sa se verite menm si enfòmasyon sou sante w la ta va sou yon sistèm òdinatè oswa sou papye.

Lè w siyen fòm sa a, ou konsanti pou patise nan *My Health GPS*. Mwen dakò pou m patise aktivman, epi mwen konprann ke mwen ka chanje lide m.

Mwen te li ak konprann enfòmasyon ki nan dokiman sa a epi yo te ban mwen chans pou m te poze kesyon. Mwen konprann patisipasyon mwen volontè epi mwen lib pou rale kò m nan pwogram sa a nenpòt ki lè, san m pa bay pou ki rezon epi san senkòb.

Non Patipan an (Ekri an gran lèt)

Dat Nesan

Siyen Non Patipan an

Dat Jodia

Siyen Non Paran/Gadyen/ Reprezantan Legal (Si li aplikab)

Dat Jodia





माई हेल्थ जी.पी.एस. (My Health GPS) कार्यक्रम में सहभागी होने के लिए सहमति पत्र (Hindi)

कृपया फॉर्म पर हस्ताक्षर करने से पूर्व इस में दी गई जानकारी ध्यान से पढ़ें।

डिस्ट्रिक्ट ऑफ कोलम्बिया मेडिकेड (District of Columbia Medicaid) द्वारा *माई हेल्थ जी.पी.एस.* कार्यक्रम प्रस्तावित किया जा रहा है। स्वस्थ रहने के लिए जरूरी देखभाल में ये कार्यक्रम आपकी सहायता करेगा। *माई हेल्थ जी.पी.एस.* कार्यक्रम से जुड़ना पूर्णतः स्वैच्छिक है। अगर आप इस कार्यक्रम में नहीं जुड़ना चाहते हैं, तब भी मेडिकेड की सेवाएँ आपको उपलब्ध रहेंगी।

***माई हेल्थ जी.पी.एस.* के सहयोगी किस प्रकार एकसाथ काम करते हैं**

माई हेल्थ जी.पी.एस. का मुख्य उद्देश्य है सारे अस्पताल एवं स्वास्थ्य सुविधाएं प्रदान करनेवाली अन्य संस्थाएँ साथ मिलकर काम करें, ताकि बेहतर स्वास्थ्य सुविधा प्रदान की जा सकें। अगर आप इस कार्यक्रम से जुड़ते हैं, तो आपके स्वास्थ्य की जानकारी अस्पतालों एवं इन संस्थाओं को दी जा सकती है, ताकि आपको बेहतर सुविधा मिले। यह आपकी पिछली तथा भविष्य की स्वास्थ्य संबंधी जानकारी के साथ दी जा सकती है।

गुप्तता का अधिकार

आपकी स्वास्थ्य संबंधी जानकारी आपकी निजी जानकारी है। इस जानकारी को बिना कानून का पालन किये किसी दूसरे को नहीं दिया जा सकता है। जो संस्थाएँ स्वास्थ्य संबंधी सुविधाये या सामुदायिक स्वास्थ्य सुविधा देती हैं उनको इस कानून का पालन करना अनिवार्य है। वे आपकी जानकारी के बिना या कानून के विरुद्ध जा कर इस जानकारी को किसी और के साथ बाँट नहीं सकते, चाहे यह जानकारी कंप्यूटर में हो या कागज पर लिखित हो।

इस फॉर्म पर हस्ताक्षर करके मैं *माई हेल्थ जी.पी.एस.* कार्यक्रम से जुड़ने की सहमति देता / देती हूँ। मैं तत्परता से इसमें सहभागी रहूँगा / रहूँगी, मुझे यह जानकारी भी है की मैं जब चाहूँ इस कार्यक्रम से अलग हो सकता / सकती हूँ।

मैंने इस में लिखी जानकारी पढ़ी और समझी है, एवं मुझे सवाल पूछने का मौका भी दिया गया है। मैं यह भी समझता हूँ कि मेरा सहभाग स्वैच्छिक है, और मैं अपनी मर्जी से कोई कारण दिए बिना या कोई भी कीमत चुकाए बिना अपना नाम वापस ले सकता / सकती हूँ।

सहभागी का नाम (कृपया प्रिंट करें)

जन्म तारीख

सहभागी के हस्ताक्षर

आज की तारीख

पालक / कानूनी प्रतिनिधि के हस्ताक्षर
(उचित विकल्प चुने)

आज की तारीख





Daim Ntawv Pom Zoo Koom Qhov Khoos Kas *My Health GPS* (Hmong)

Thov koj nyeem tag nrho cov lus qhia hauv daim ntawv no kom zoo ua ntej koj yuav kos npe rau.

My Health GPS yog ib qho khoos kas uas pab los ntawm Pab Pawg Tswj Xyuas Cov Medicaid Nyob Rau Ib Cheeb Tsam Ntawm Lub Nroog Columbia. Nws pab kom koj tau txais cov kev saib xyuas kho mob uas koj xav tau txhawm rau kom koj muaj kev noj qab haus huv. Nws yog koj txoj kev xaiv yuav koom qhov Khoos Kas *My Health GPS*. Txawm tias koj tsis xav koom los, koj yeej tseem yuav tau txais koj cov kev pab cuam kho mob los ntawm Medicaid ib yam nkaus.

***My Health GPS* Cov Tswv Koom Lag Luam Ua Ke yuav ua hauj lwm ua ke tau li cas**

Ib feem uas tseem ceeb ntawm *My Health GPS* yog kev muab siab rau saib xyuas kom meej tseeb tias cov tsev kho mob thiab koj txhua tus kws muab kev pab kho mob ntsig txog kev noj qab haus huv yuav tsum ua hauj lwm kom raug raws li kev ua tswv koom lag luam ua ke txhawm rau muab kev saib xyuas kho mob kom tau zoo dua qub rau koj. Yog tias koj koom qhov khoos kas no, koj cov ntaub ntawv kho mob yuav raug muab qhia rau txhua lub tsev kho mob thiab txhua tus kws muab kev pab kho mob uas muab kev saib xyuas kho mob rau koj ntawd paub. Cov ntaub ntawv no xam tag nrho cov yav tas los cov yav tom ntej uas muaj nyob rau hauv koj cov ntaub ntawv kho mob tib si.

Txoj cai txog kev ceev ntaub ntawv ntiag tug

Koj cov ntaub ntawv kho mob yuav raug ceev ntiag tug tsis pub leej twg paub. Peb yuav tsis muab qhia rau lwm tus neeg paub ntshwj tsis yog tias lawv yuam kev cai lij choj xwb. Txhua lub tsev kho mob los yog txhua tus kws muab kev pab kho mob yuav tsum hwm ua raws txhua txoj kev cai lij choj no. Lawv tsis muaj cai muab koj cov ntaub ntawv kho mob qhia rau lwm tus neeg paub tshwj tsis yog tias koj pom zoo los yog kev cai lij choj teev tseg cia tias lawv muaj cai muab koj cov ntaub ntawv kho mob qhia rau lwm tus neeg paub. Nod yog qhov tseeb txawm tias koj cov ntaub ntawv kho mob ntawd yuav nyob rau hauv kab ke koos phis tawj los yog ib daim ntawv twg xwb los xij.

Kev kos npe rau daim ntawv no, kuv pom zoo koom qhov khoos kas *My Health GPS*. Kuv pom zoo koom yam txaus siab hlo, thiab kuv nkag siab tias kuv muaj cai pauv siab tsis koom los tau.

Kuv tau nyeem thiab nkag siab txog cov lus qhia nyob rau hauv daim ntawv no zoo lawm thiab tau txais lub cib fim nug txog txhua yam kuv xav paub tag lawm. Kuv nkag siab tias kuv qhov kev koom tes no yog los ntawm kev txaus siab thiab kuv muaj cai pauv siab tsis koom tau txhua lub sij hawm, yam tsis tas yuav muaj lus phim thawj thiab them nqi dab tsi hlo li.

Tus Neeg Koom Lub Npe (thov sau rau)

Hnub Yug

Tus Neeg Koom Kos Npe Rau

Hnub No Yog Hnub Tim

Niam Thiab Txiv/Tus Neeg Saib Xyuas/Tus Sawv
Raug Raws Kev Cai Lij Choj Kos Npe Rau (Yog Tias Muaj)

Hnub No Yog Hnub Tim





Consenso alla partecipazione ne Consenso alla partecipazione nel programma della Mia Salute GPS (Italian)

Si prega di leggere tutte le informazioni su questo modulo prima di firmarlo.

La Mia Salute GPS è un programma offerto dal Medicaid del distretto della Columbia e consente di ottenere le cure necessarie per mantenersi in buona salute. La sua scelta di partecipare a questo programma è volontaria: se non si desidera partecipare,, i servizi di Medicaid verranno erogati in ogni modo.

Come il programma *La Mia Salute GPS* collabora con altri operatori sanitari

Una grande parte della Mia Salute GPS consiste nell' assicurarsi che esista una collaborazione fra ospedali e vari operatori sanitari al fine di provvedere una cura migliore ed efficiente. Una volta iscritti, le informazioni sanitarie possono essere condivise con questi enti, e possono includere dati precedenti derivati dalla cartella medica esistenti o proiezioni future .

Diritto alla privacy.

Le informazioni sanitarie sono private e possono solo essere date a persone che hanno per legge il diritto di riceverle. Tutti gli operatori sanitari che hanno il diritto di accesso devono far ciò attenendosi alla legge, quindi non possono condividere le vostre informazioni a meno che non ricevano il vostro consenso oppure quando consentito per legge . Il permesso di condivisione si estende alle informazioni stampate o elettroniche.

Con la mia firma su questo modulo io acconsento a partecipare al programma La Mia Salute GPS in maniera attiva ma con la stipulazione che io possa cambiare idea nel futuro.

Attesto che ho letto e capito le informazioni contenute in questo documento e che mi è stata data l'opportunità di porre delle domande. Mi rendo conto che la mia partecipazione è volontaria e che posso sempre annullare il mio consenso senza specificarne il motivo e senza alcun costo.

Nome del partecipante (in stampatello)

Data di nascita

Firma del partecipante

Data di oggi

Genitore/tutore/firma del rappresentante legale
(se applicabile)

Data di oggi





My Health GPS プログラムへの加入同意書 (Japanese)

署名前に、本書内のすべての情報をお読みください。

My Health GPS は、コロンビア特別区のメディケイドによって提供されるプログラムです。健康を維持するために必要な医療受診を扶助します。**My Health GPS** プログラムに加入するかどうかは、ご自分で選択することができます。本プログラムへの加入を希望されない場合も、メディケイドのサービスを受けることができます。

My Health GPS パートナーの協力体制

My Health GPS では、病院や医療機関が加入者へのより良い医療提供のために連携します。このプログラムに参加すると、病院や医療機関があなたの健康情報を共有することができます。これにより、これまでの病歴や将来の健康情報があなたの健康記録に記載されます。

プライバシーの権利

健康情報は個人情報です。法律を遵守せずに、第三者へこのような情報を提供することはできません。あなたの健康情報を閲覧することが可能な医療機関や社会福祉サービス提供者は、関係する法律すべてに従わなければなりません。あなたの同意なく、または法律で第三者への情報開示が求められる場合を除いて、これらの機関はあなたの健康情報を共有することはできません。健康情報がコンピュータシステム上にあるか、印刷形式であるかを問わず、この規定が適用されます。

本書に署名することにより、私は My Health GPS への加入に同意します。私は積極的に加入に同意します。また意思を変更することが可能であることを理解しています。

私は本書内の情報を読んで理解しました。また質問する機会を与えられていました。私は自分の加入が自発的であること、いつでも理由なくまた費用を支払うことなく自由に脱退できることを理解しています。

加入者の氏名（活字体）

生年月日

加入者の署名

署名日

親権者/保護者/ 法定代理人の署名
(該当する場合)

署名日





Insert
Your Logo
Here

마이헬스 GPS 프로그램(My Health GPS Program) 참여 동의서 (Korean)

서명하기 전에 이 양식의 모든 정보를 읽어 보시기 바랍니다.

마이헬스 GPS는 콜롬비아 DC 메디케이드(District of Columbia Medicaid)가 제공하는 프로그램입니다. 건강한 삶을 영위하는 데 필요한 치료를 받을 수 있도록 지원합니다. 마이헬스 GPS 프로그램 가입은 귀하의 선택에 달려있습니다. 가입을 원하지 않아도 메디케이드 서비스는 여전히 받을 수 있습니다.

마이헬스 GPS 파트너의 협력 방식

마이헬스 GPS 프로그램의 주된 목적은 병원 및 귀하의 의료 서비스 제공자가 귀하에게 더 나은 의료를 제공하도록 파트너로서 협력하도록 하는 것입니다. 프로그램에 가입하면, 귀하의 건강 정보가 귀하를 치료하는 병원 및 의료 제공자와 공유될 수 있습니다. 이러한 정보에는 귀하의 건강 기록 내에 있는 과거 또는 미래의 정보가 포함될 수 있습니다.

개인정보 보호 권리

귀하의 건강 정보는 비공개입니다. 법규를 준수하기 위한 목적을 제외하고는 타인에게 제공할 수 없습니다. 귀하의 건강 정보를 볼 수 있는 모든 의료 서비스 제공자 또는 지역 사회 서비스 제공자는 이러한 모든 법률을 준수해야 합니다. 귀하가 동의하거나 법률에 따라 타인에게 정보를 제공할 수 있다고 규정된 경우 이외에는 귀하의 정보를 공유할 수 없습니다. 귀하의 건강 정보가 컴퓨터 시스템이나 서류에 있다고 하더라도 마찬가지입니다.

이 양식에 서명함으로써, 본인은 마이헬스 GPS 프로그램에 참여하기로 동의합니다. 본인은 적극적으로 참여할 것에 동의하며, 의사 변경이 가능함을 이해합니다.

본인은 이 문서의 정보를 읽고 이해했으며 질문할 기회가 주어졌습니다. 본인은 본인의 참여가 자발적이며, 언제든지 사유 제출 없이 그리고 비용 없이 의사를 철회할 수 있음을 이해합니다.

참가자 이름(정자로 기입)

생년월일

참가자 서명

오늘 날짜

부모/보호자/법정 대리인 서명
(해당하는 경우)

오늘 날짜





同意参加 *我的健康 GPS* 计划 (Mandarin)

请在签名之前阅读本表的所有信息

我的健康 GPS (My Health GPS) 是一个由哥伦比亚特区医疗补助计划 (Medicaid) 提供的计划，可帮助您获得所需的护理，让您保持身体健康。是否加入 *我的健康 GPS* 计划是您自己的选择。如果您不想加入，您仍然可以获得您的医疗补助计划服务。

我的健康 GPS 如何与合作伙伴协作

我的健康 GPS 的很大一部分就是确保，各家医院和您的任何医疗保健提供者能够作为合作伙伴协作，一起更好地照护您。如果您加入本计划，您的健康信息可能会与照护您的医院和医疗保健提供者分享。这可能包括您健康记录中过去或将来的信息。

隐私权

您的健康信息是您的私人信息，不会交给不遵守法律的他人。可以看到您健康信息的所有医疗保健提供者或社区服务提供者都必须遵守所有这些法律。除非您同意或法律说明可以将信息提供给他们，否则他们不能分享您的信息。即使您的健康信息已留在计算机系统或纸页上也是如此。

签署本表时，我即同意参与 *我的健康 GPS*。我同意积极参与，而且我明白我可以改变主意。

我已阅读并理解本文档中的信息，并已有机会提出问题。我明白我的参与纯属自愿，我可以随时自由退出，无需任何理由，也无需支付任何费用。

参与者姓名（请清楚填写）

出生日期

参与者签名

今天的日期

家长/监护人/法定代理人签名
(如适用)

今天的日期





Zgoda Udziału w Programie *My Health GPS* (Moje Zdrowie GPS) (Polish)

Proszę przeczytać uważnie wszystkie informacje przed podpisaniem.

My Health GPS (Moje Zdrowie GPS) jest programem oferowanym przez Medicaid w District of Columbia. Pomaga w zyskać opiekę, potrzebną by być zdrowym. Dołączenie do programu *My Health GPS* (Moje Zdrowie GPS), jest twoim wyborem. Jeżeli nie chcesz z niego skorzystać, nadal będziesz otrzymywać usługi Medicaid.

W jaki sposób Parterzy *My Health GPS* (Moje Zdrowie GPS) pracują razem

Dużą częścią *My Health GPS* (Moje Zdrowie GPS) jest upewnienie się, że szpitale i ktokolwiek z twojej służby zdrowia, współpracują, aby się lepiej tobą zaopiekować. Jeżeli dołączysz do programu, twoje informacje zdrowotne mogą być udostępnione szpitalom oraz pracownikom służby zdrowia, którzy się tobą opiekują. To może dotyczyć informacji z przeszłości, lub przyszłości w twojej karcie zdrowia.

Prawo do prywatności

Twoje informacje medyczne są prywatne. Nie mogą zostać udostępnione innym osobom, z wyjątkiem drogi prawnej. Wszyscy pracownicy służby zdrowia i przychodni, którzy mają dostęp do twoich informacji zdrowotnych, muszą przestrzegać tych wszystkich praw. Nie mogą udostępniać twoich informacji, z wyjątkiem twojego wyrażenia zgody, lub jeśli prawo nakazuje przekazania tych informacji innym osobom. Te prawa obejmują twoje informacje zdrowotne w komputerze oraz te na papierze.

Podpisując ten formularz, zgadzam się na udział w programie *My Health GPS* (Moje Zdrowie GPS). Zgadzam się brać aktywny udział w programie, i rozumiem, że mogę zmienić zdanie.

Przeczytałem (łam) i zrozumiałem (łam) informacje w tym dokumencie, oraz miałem (łam) szansę zadać pytania na ten temat. Rozumiem, że mój udział jest dobrowolny, o mogę się wycofać w każdej chwili, bez podania powodu, i bez kosztów.

Imię i Nazwisko Uczestnika (drukowanymi literami)

Data Urodzenia

Podpis Uczestnika

Dzisiejsza Data

Podpis Rodzica/Opiekuna/ Przedstawiciela Prawnego
(W razie konieczności)

Dzisiejsza Data





Consentimento para participar no programa *My Health GPS* (Portuguese)

Leia todas as informações neste formulário antes de assiná-lo.

My Health GPS é um programa oferecido pelo Medicaid do Distrito de Colúmbia. Ele lhe ajuda a receber o atendimento necessário para se manter saudável. É sua opção participar do programa *My Health GPS*. Caso não queira participar, você ainda receberá seus serviços do Medicaid.

Como os parceiros do *My Health GPS* trabalham juntos

Uma grande parte do *My Health GPS* é garantir que os hospitais e prestadores de atendimento de saúde trabalhem como parceiros para melhor cuidar de você. Se participar do programa, suas informações de saúde poderão ser compartilhadas com hospitais e prestadores de atendimento de saúde que cuidam de você. Isso poderia incluir informações do passado ou futuro em seu histórico de saúde.

Direito à privacidade

As informações sobre sua saúde são privadas. Elas não podem ser dadas a outras pessoas, a menos que elas sigam a lei. Todos os prestadores de serviços de saúde ou comunitários que podem ver suas informações de saúde devem obedecer a todas essas leis. Eles não podem compartilhar suas informações, a menos que você aceite ou haja obrigação legal de fornecer as informações a outras pessoas. Isso vale até mesmo se suas informações de saúde estiverem em um sistema de computador ou em papel.

Ao assinar este formulário, eu aceito participar no *My Health GPS*. Eu aceito participar ativamente e entendo que posso mudar de ideia.

Eu li e entendi as informações neste documento, e tive a oportunidade de tirar dúvidas. Eu entendo que minha participação é voluntária e que sou livre para desistir a qualquer momento, sem qualquer motivo e sem custos.

Nome do participante (legível)

Data de nascimento

Assinatura do participante

Data de hoje

Assinatura dos pais/guardião/representante legal (Se for o caso)

Data de hoje





ਮੇਰੀ ਸਿਹਤ GPS ਪ੍ਰੋਗਰਾਮ ਵਿੱਚ ਭਾਗ ਲੈਣ ਲਈ ਸਹਿਮਤੀ (Punjabi)

ਫਾਰਮ ਉੱਤੇ ਦਸਤਖਤ ਕਰਨ ਤੋਂ ਪਹਿਲਾਂ ਕਿਰਪਾ ਕਰਕੇ ਇਸ ਉੱਤੇ ਦਿੱਤੀ ਗਈ ਸਾਰੀ ਜਾਣਕਾਰੀ ਧਿਆਨ ਨਾਲ ਪੜ੍ਹੋ।

ਮੇਰੀ ਸਿਹਤ GPS ਕੋਲੰਬੀਆ ਜ਼ਿਲ੍ਹੇ ਦੀ ਮੈਡੀਕੇਡ ਵੱਲੋਂ ਪੇਸ਼ ਕੀਤਾ ਗਿਆ ਇੱਕ ਪ੍ਰੋਗਰਾਮ ਹੈ। ਇਹ ਤੁਹਾਨੂੰ ਸਿਹਤਮੰਦ ਰਹਿਣ ਲਈ ਲੋੜੀਂਦੀ ਦੇਖਭਾਲ ਪ੍ਰਾਪਤ ਕਰਨ ਵਿੱਚ ਮਦਦ ਕਰਦਾ ਹੈ। ਮੇਰੀ ਸਿਹਤ GPS ਪ੍ਰੋਗਰਾਮ ਵਿੱਚ ਸ਼ਾਮਲ ਹੋਣਾ ਤੁਹਾਡੀ ਆਪਣੀ ਚੋਣ ਹੈ। ਜੇਕਰ ਤੁਸੀਂ ਸ਼ਾਮਲ ਨਹੀਂ ਹੋਣਾ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਵੀ ਤੁਸੀਂ ਆਪਣੀਆਂ ਮੈਡੀਕੇਡ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰਦੇ ਰਹੋਗੇ।

ਮੇਰੀ ਸਿਹਤ GPS ਦੇ ਭਾਈਵਾਲ ਇਕੱਠੇ ਕੰਮ ਕਿਵੇਂ ਕਰਦੇ ਹਨ

ਮੇਰੀ ਸਿਹਤ GPS ਦਾ ਇੱਕ ਬਹੁਤ ਵੱਡਾ ਹਿੱਸਾ ਇਹ ਯਕੀਨੀ ਬਣਾਉਂਦਾ ਹੈ ਕਿ ਹਸਪਤਾਲ ਅਤੇ ਤੁਹਾਡਾ ਕੋਈ ਵੀ ਸਿਹਤ ਸੰਭਾਲ ਪ੍ਰਦਾਤਾ ਤੁਹਾਡੀ ਬਿਹਤਰ ਦੇਖਭਾਲ ਲਈ ਇਕੱਠੇ ਕੰਮ ਕਰਨ। ਜੇਕਰ ਤੁਸੀਂ ਪ੍ਰੋਗਰਾਮ ਵਿੱਚ ਸ਼ਾਮਲ ਹੁੰਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੀ ਦੇਖਭਾਲ ਕਰਨ ਵਾਲੇ ਹਸਪਤਾਲਾਂ ਅਤੇ ਪ੍ਰਦਾਤਾਵਾਂ ਨਾਲ ਤੁਹਾਡੀ ਸਿਹਤ ਜਾਣਕਾਰੀ ਸਾਂਝੀ ਕੀਤੀ ਜਾ ਸਕਦੀ ਹੈ। ਇਸ ਵਿੱਚ ਤੁਹਾਡੇ ਡਾਕਟਰੀ ਇਤਿਹਾਸ ਦੇ ਅੰਦਰ-ਅੰਦਰ ਅਤੀਤ ਦੀ ਅਤੇ ਭਵਿੱਖ ਦੀ ਜਾਣਕਾਰੀ ਸ਼ਾਮਲ ਹੋ ਸਕਦੀ ਹੈ।

ਨਿੱਜਤਾ ਦਾ ਅਧਿਕਾਰ

ਤੁਹਾਡੀ ਸਿਹਤ ਜਾਣਕਾਰੀ ਨਿੱਜੀ ਹੁੰਦੀ ਹੈ। ਇਹ ਹੋਰ ਲੋਕਾਂ ਨਾਲ ਸਾਂਝੀ ਨਹੀਂ ਕੀਤੀ ਜਾ ਸਕਦੀ ਹੈ ਬਸ਼ਰਤੇ ਕਿ ਉਹ ਕਾਨੂੰਨ ਦੀ ਪਾਲਨਾ ਕਰਦੇ ਹੋਣ। ਸਾਰੇ ਸਿਹਤ ਦੇਖਭਾਲ ਜਾਂ ਕਮਿਊਨਿਟੀ ਸੇਵਾ ਪ੍ਰਦਾਤਾਵਾਂ ਲਈ ਇਹਨਾਂ ਕਾਨੂੰਨਾਂ ਦੀ ਪਾਲਨਾ ਕਰਨਾ ਜ਼ਰੂਰੀ ਹੈ, ਜੋ ਤੁਹਾਡੀ ਸਿਹਤ ਜਾਣਕਾਰੀ ਦੇਖ ਸਕਦੇ ਹਨ। ਉਹ ਤੁਹਾਡੀ ਜਾਣਕਾਰੀ ਤੋਂ ਬਿਨਾਂ ਤੁਹਾਡੀ ਮਰਜ਼ੀ ਅਤੇ ਕਾਨੂੰਨ ਅਧੀਨ ਲੋੜ ਤੋਂ ਇਲਾਵਾ ਕਿਸੇ ਹੋਰ ਨਾਲ ਸਾਂਝੀ ਨਹੀਂ ਕਰ ਸਕਦੇ। ਭਾਵੇਂ ਤੁਹਾਡੀ ਸਿਹਤ ਜਾਣਕਾਰੀ ਕੰਪਿਊਟਰ ਵਿੱਚ ਹੈ ਜਾਂ ਦਸਤਾਵੇਜ਼ੀ ਰੂਪ ਵਿੱਚ, ਇਹ ਸਭ ਉੱਤੇ ਲਾਗੂ ਹੁੰਦਾ ਹੈ।

ਇਸ ਫਾਰਮ ਉੱਤੇ ਦਸਤਖਤ ਕਰਕੇ, ਮੈਂ ਮੇਰੀ ਸਿਹਤ GPS ਵਿੱਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਸਹਿਮਤ ਹਾਂ। ਮੈਂ ਸਰਗਰਮੀ ਨਾਲ ਭਾਗ ਲਈ ਸਹਿਮਤ ਹਾਂ ਅਤੇ ਸਮਝਦਾ/ਸਮਝਦੀ ਹਾਂ ਕਿ ਮੈਂ ਆਪਣਾ ਮਨ ਬਦਲ ਸਕਦਾ/ਸਕਦੀ ਹਾਂ।

ਮੈਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਵਿੱਚ ਦਿੱਤੀ ਗਈ ਜਾਣਕਾਰੀ ਪੜ੍ਹ ਅਤੇ ਸਮਝ ਲਈ ਹੈ ਅਤੇ ਮੈਨੂੰ ਸਵਾਲ ਪੁੱਛਣ ਦੇ ਮੌਕੇ ਦਿੱਤੇ ਗਏ ਸਨ। ਮੈਂ ਸਮਝਦਾ/ਸਮਝਦੀ ਹਾਂ ਕਿ ਮੇਰੀ ਭਾਗੀਦਾਰੀ ਮੇਰੀ ਮਰਜ਼ੀ ਉੱਤੇ ਨਿਰਭਰ ਕਰਦੀ ਹੈ ਅਤੇ ਮੈਂ ਕਿਸੇ ਵੀ ਸਮੇਂ ਬਿਨਾਂ ਕੋਈ ਕਾਰਨ ਦਿੱਤੇ ਅਤੇ ਬਿਨਾਂ ਕਿਸੇ ਖਰਚੇ ਉੱਤੇ ਬਾਹਰ ਹੋਣ ਲਈ ਸੁਤੰਤਰ ਹਾਂ।





ਭਾਗੀਦਾਰ ਦਾ ਨਾਮ (ਕਿਰਪਾ ਕਰਕੇ ਪ੍ਰਿੰਟ ਕਰੋ)

ਜਨਮ ਮਿਤੀ

ਭਾਗੀਦਾਰ ਦੇ ਦਸਤਖਤ

ਅੱਜ ਦੀ ਮਿਤੀ

ਮਾਤਾ-ਪਿਤਾ/ਸਰਪ੍ਰਸਤ/ਕਾਨੂੰਨੀ ਨੁਮਾਇੰਦੇ ਦੇ ਦਸਤਖਤ
(ਜੇਕਰ ਲਾਗੂ ਹੁੰਦਾ ਹੈ)

ਅੱਜ ਦੀ ਮਿਤੀ





Ogolow Ka qeybqaadashada Barnaamijka *My Health GPS* (Somali)

Fadlan aqri dhammaan warbixinta ku jirto foomkaan ka hor inta aadan saxiixin.

My Health GPS waa barnaamij la siiyay Degmada Columbia Medicaid. Waxay kugu caawineysaa inaad heshid daryeelka aad u baahantahay inaad caafimaad ku ahaatid. Waa dooqaaga inaad ku soo biirtid Barnaamijka *My Health GPS*. Haddii aadan rabin inaad ku soo biirtid, waxaad weli heleysaa adeegyadaada Medicaid.

Sida Jaalalka *My Health GPS* usula shaqeeyaan

Qeyb weyn ee *My Health GPS* waxay hubineysaa isbitaalada iyo mid walba ee bixiyayaasha daryeelkaaga caafimaad u shaqeeyso sida jaalalka sida wanaagsan kuu daryeelo. Haddii aad ku soo biirtid barnaamijka, warbixintaada caafimaad waxaa lala wadaagi karaa isbitaalada iyo bixiyayaasha adiga ku daryeelo. Tani waxaa ku jiri kartaa warbixinta la soo dhaafay iyo mida mustaqbalka ee gudaha diiwaankaaga caafimaad.

Xaquuqda arimaha gaarka

Warbixintaada caafimaad waa gaar. Lama siin karo dadka kale illaa ay raacaan sharciga. Dhammaan daryeelka caafimaad ama bixiyayaasha adeega bulshada ee arki karo warbixintaada caafimaad waa inay cadeecaan dhammaan sharciyadaan. Ma wadaagi karaan warbixintaada illaa aad ogolaatid ama sharciga dhaho inay siin karaan warbixinta dadka kale. Tani waa dhacdo dhab ah xittaa haddii warbixintaada caafimaad ay ku jirto qalabka kumbiyuutarka ama warqad.

Saxiixid foomkaan, waxaan ogolaan karaa inaan ka qeybqaato *My Health GPS*. Waan ogolaaday inaan si firfircoon uga qeybqaato, iyo waan fahamsannahay inaan badeli karo qalbigeyga.

Waan aqriyay oo waan fahmay warbixinta warqadaan ku jirto oo waxaa la siiyay fursada lagu weydiinayo su'aalo. Waan fahamsannahay in ka qeybqaadasheyda ay iqtiyaar tahay iyo in xur u ahy inaan ka laaban karo xili walba, iyada oo aan jirin wax sabab ah oo aan sheego iyo qarash la'aan.

Magaca Ka qeybqaataha (fadlan daabac)

Taariiqda Dhalashada

Saxiixa Ka qeybqaataha

Taariiqda Maanta

Saxiixa Waalidka/Masuulka/ Wakiilka Sharciga (Haddii ay quseyso)

Taariiqda Maanta





Consentimiento para participar en el programa *El GPS de mi Salud* (Spanish)

Por favor lea toda la información en este formulario antes de firmarlo.

El GPS de mi Salud es un programa ofrecido por el Medicaid del Distrito de Columbia. El mismo le ayuda a obtener el cuidado que necesita para estar saludable. Usted puede aprovechar del programa *GPS de mi salud* voluntariamente. Si no deseara participar, aún recibiría sus beneficios de Medicaid.

Cómo trabajan conjuntamente los Socios del programa *GPS de mi salud*

Una gran parte del programa *El GPS de mi Salud* encierra el asegurarse de que los hospitales y cualquier otro proveedor de salud trabajan conjuntamente para ofrecerle mejor cuidado médico. Si usted decide aprovechar de este programa, es posible que la información médica suya sea compartida con hospitales y proveedores de salud. Ello puede incluir información contenida en sus archivos médicos en el pasado y en el futuro.

Su derecho a la privacidad

La información relacionada con su salud es privada. La misma no se puede dar a otras personas a menos que sea en forma legal. Toda la comunidad del cuidado de la salud o los proveedores de servicios relacionados con el cuidado de la salud que tuviesen acceso a sus archivos están obligados a cumplir con la ley. Como tal, no pueden compartir su información a menos que usted lo apruebe o a menos que la ley lo permita. Esto se aplica aún cuando su información esté en una computadora o en papel.

Al firmar este formulario, acepto participar en el programa *El GPS de mi salud*. También acepto participar activamente en el programa y comprendo que puedo cambiar de opinión al respecto en cualquier momento.

He leído y comprendo la información contenida en este documento y también que me han dado una oportunidad de hacer preguntas al respecto. Comprendo que mi participación es voluntaria y que puedo decidir no participar en cualquier momento, sin dar razón alguna y sin pagar nada.

Nombre del participante (por favor imprima)

Fecha de nacimiento

Firma del participante

Fecha de hoy

Firma del padre, guardián o representante (si correspondiese)

Fecha de hoy





Insert
Your Logo
Here



Pahintulot upang Lumahok sa Programang *My Health GPS* (Tagalog)

Pakibasahin ang lahat ng impormasyon sa form na ito bago mo ito pirmahan.

Ang *My Health GPS* ay programang iniaalok ng Medicaid ng Distrito ng Columbia. Tumutulong ito upang makuha ang pangangailangan na kailangan mo upang maging malusog. Kagustuhan mo na sumali sa Programang *My Health GPS*. Kung ayaw mong sumali, makukuha mo parin ang mga serbisyo mong Medicaid.

Paano sama-samang nagtatrabaho ang mga Kasosyo ng *My Health GPS*

Ang malaking bahagi ng *My Health GPS* ay ang pagtiyak na ang mga ospital at alinman sa mga tagapaglaan ng pangangalaga sa kalusugan mo ay nagtatrabaho bilang mga kasosyo upang mas mahusay kang mapangalagaan. Kapag sumali ka sa programang ito, ang impormasyon mo sa kalusugan ay maaaring maibahagi sa mga ospital at provider na nangangalaga sa iyo. Maaaring maglaman ito ng impormasyon mula sa nakalipas o sa hinaharap sa loob ng iyong rekord sa kalusugan.

Karapatan sa pribasya

Ang impormasyon mo sa kalusugan ay pribado. Hindi ito maaaring ibigay sa ibang tao maliban kung sinusunod nila ang batas. Ang lahat ng provider para sa pangangalagang pangkalusugan o serbisyo sa komunidad na makakakita ng impormasyon ng iyong kalusugan ay dapat sumunod sa mga batas na ito. Hindi nila maaaring ibahagi ang impormasyon mo maliban kang sumasang-ayon ka o isinasaad ng batas na maaari nilang ibigay ang impormasyon sa ibang tao. Totoo ito kahit na ang impormasyon mo sa kalusugan ay nasa computer system o sa papel.

Sa pamamagitan ng paglagda sa form na ito, pinahihintulutan ko na lumahok sa *My Health GPS*. Sumasangayon ako na aktibong lumahok, at nauunawaan ko na maaaring magbago ang isip ko.

Nauunawaan ko at nauunawaan na ang impormasyon sa dokumentong ito at binigyan ng pagkakataon na magtanong. Nauunawaan ko na ang pakikilahok ko ay boluntaryo at malaya kong bawiin sa anumang oras, nang hindi nagbibigay ng anumang dahilan at walang bayad.

Pangalan ng Kalahok (paki-print)

Petsa ng Kapanganakan

Lagda ng Kalahok

Petsa Ngayon

Lagda ng Magulang/Tagapag-alaga/Legal na Kinatawan (Kung Naaangkop)

Petsa Ngayon





Согласие на участие в программе GPS Моего Здоровья (Russian)

Пожалуйста, прочитайте всю информацию на этой форме перед тем как ее подписать.

GPS Моего Здоровья - это программа, предлагаемая от Medicaid Округа Колумбия. Она помогает вам получить всю необходимую заботу чтобы быть здоровым. Присоединиться к программе GPS Моего Здоровья - это Ваш выбор. Если вы не желаете присоединиться, вы все равно получите покрытие от Medicaid.

Как партнеры GPS Моего Здоровья работают вместе

Большая часть работы GPS Моего Здоровья - это убедиться что больницы и любые другие провайдеры медицинских услуг работают вместе в качестве партнеров для того чтобы лучше ухаживать за вами. Если вы присоединитесь к программе, то вся информация о вашем здоровье может быть разделена с больницами и любыми другими провайдерами, которые будут о вас заботиться. Это может включить информацию из прошлого или в будущем из ваших медицинских записей.

Право на неприкосновенность личной жизни

Информацию о вашем здоровье является частной. Она не может быть предоставлена другим людям за исключением когда они следуют закону. Все провайдеры общественного здравоохранения, которые могут видеть всю информацию о вашем здоровье, должны соблюдать все эти законы. Они не имеют право на передачу вашей информации, за исключением когда вы согласны с этим или закон дает им разрешение на дачу информации другим людям. Это все является правдой даже если информация о вашем здоровье хранится в компьютерной системе или на бумаге.

Подписав эту форму, я даю согласие на участие в программе GPS Моего Здоровья. Я соглашаюсь на принятие активного участия и Я понимаю, что я могу изменить свое решение.

Я прочитал и понял информацию данную в этом документе и мне была предоставлена возможность задать вопросы. Я понимаю, что мое участие является добровольным и что я вправе отказаться от участия в любое время без объяснения причин и без затрат.





Имя Участника (Пожалуйста,напечатайте)

Дата Рождения

Роспись Участника

Сегодняшняя Дата

Родитель/Опекун/ Представитель

Сегодняшняя Дата





Insert
Your Logo
Here



Đơn đồng ý tham gia chương trình *My Health GPS*
(Hệ thống định vị y tế toàn cầu của tôi)
(Vietnamese)

Hãy đọc tất cả các thông tin trên mẫu này trước khi ký.

My Health GPS là một chương trình của District of Columbia Medicaid (đơn vị Trợ Giúp Y Tế District of Columbia). Chương trình này giúp bạn nhận được sự chăm sóc sức khỏe cần thiết. Tham gia *My Health GPS* là sự lựa chọn của bạn. Nếu bạn không muốn tham gia, bạn vẫn sẽ nhận được các dịch vụ trợ giúp y tế Medicaid.

Cách các đối tác *My Health GPS* làm việc cùng nhau

Một bộ phận lớn *My Health GPS* đang đảm bảo các bệnh viện và bất cứ đơn vị chăm sóc sức khỏe nào của bạn đều làm việc với tư cách là đối tác chương trình nhằm chăm sóc tốt hơn cho bạn. Nếu bạn tham gia vào chương trình, thông tin y tế của bạn có thể được chia sẻ tới các bệnh viện và đơn vị chăm sóc sức khỏe. Điều này có thể bao gồm thông tin trong hồ sơ y tế của bạn từ quá khứ đến tương lai.

Quyền riêng tư

Thông tin y tế của bạn được giữ bí mật. Thông tin đó sẽ không được trao cho ai khác trừ phi họ đang thực hiện theo luật pháp. Tất cả các đơn vị cung cấp dịch vụ y tế hoặc cộng đồng muốn xem thông tin y tế của bạn đều phải tuân thủ theo các luật này. Họ không thể chia sẻ thông tin của bạn trừ phi bạn đồng ý hoặc luật pháp cho thấy họ có thể đưa thông tin cho người khác. Điều này xác thực ngay cả khi thông tin y tế của bạn nằm trong hệ thống máy tính hoặc trên giấy.

Bằng việc ký vào mẫu này, tôi đồng ý tham gia chương trình *My Health GPS*. Tôi đồng ý tích cực tham gia và tôi hiểu tôi có thể thay đổi ý kiến.

Tôi đã đọc và hiểu thông tin trong tài liệu này và đã có cơ hội được hỏi các câu hỏi. Tôi hiểu sự tham gia của tôi là tự nguyện và tôi được tự do rút lại bất cứ lúc nào mà không cần đưa ra lý do và không phải chịu phí tổn.

Tên người tham gia (in hoa)

Ngày sinh

Chữ ký của người tham gia

Ngày hiện tại

Chữ ký của cha hoặc mẹ/Người giám hộ/
Đại diện pháp luật
(Nếu có)
Appendix E

Ngày hiện tại





Care plan update _____

Please circle the reason:

- ❖ Location
- ❖ Customer Service
- ❖ Personal Preference
- ❖ Another known Provider
- ❖ Other_____

MY HEALTH GPS

PROVIDER CHANGE FORM

TO BE COMPLETED BY/FOR MY HEALTH GPS BENEFICIARIES

This form must be completed when the beneficiary wishes to change their attributed MHGPS provider to a new MHGPS provider. Please submit by secure email to the receiving or sending Provider for approval. Once approved the last signing Provider will send to myhgps@dc.gov or return to DHCF by mail: 441 4th St, NW, Suite 900 South, Washington, DC 20001

Name of Beneficiary:	Date of Birth:	Medicaid Number:	MCO, if applicable
Attributed (Sending) My GPS Provider			
New Attributed (Receiving) My GPS Provider	_____ Sending Health Home Director/Designee/Date (Print and sign Name)	_____ Accept/Deny of transfer (Circle)	
	_____ Receiving Health Home Director/Designee/Date (Print and sign Name)	_____ Accept/Deny of transfer (Circle)	

I understand that I may request to change *My Health GPS* providers at any time. The effective date of my Provider change will be based on the following:

- If my request to change providers is received by DHCF prior to the twentieth (20th) day of the month, it will be effective the first day of the month following the month in which DHCF was notified;
- If my request to change providers is received by DHCF on or after the twentieth (20th) day of the month, it will be effective the first day of the second month following the month in which DHCF was notified.

Based on the information above, I understand that I remain eligible to receive *My Health GPS* services from my current *My Health GPS* provider until I start services with my new provider. I will start with my new *My Health GPS* Provider on _____.

☐ Request was received by Beneficiary or Legal guardian by telephone

Date Request Received

Signature of Beneficiary or Legal Guardian (if applicable)

If Legal Guardian's Signature, print name

Date Signed _____

-For DHCF Use Only

Date DHCF received

Date Beneficiary Letter mailed

Providers notification date





MY HEALTH GPS WITHDRAWAL OF CONSENT FORM

TO BE COMPLETED BY/FOR MY HEALTH GPS BENEFICIARIES

This form must be completed when a beneficiary is enrolled in the Program and decides to end their participation. Please submit by secure email to myhgps@dc.gov or return to DHCF by mail: 441 4th St, NW, Suite 900 South, Washington, DC 20001

Please circle the reason:

- ❖ Location
- ❖ Customer Service
- ❖ Personal Preference
- ❖ Another known Provider
- ❖ Other _____

Name of Beneficiary:	Date of Birth:	Medicaid Number:
Assigned <i>My Health GPS</i> Entity:	Managed Care Organization (MCO) if applicable:	

Beneficiary initial or Staff to initial, if the consultation is done by phone, to signify the information has been discussed

When you do not want to participate in the <i>My Health GPS</i> program any longer, you need to know that:	
	Any <i>My Health GPS</i> Consent Forms that you signed in the past are no longer valid.
	Your health information will be kept by providers who already have your information. They do not have to give it back to you or delete it.
	Your personal health information will still be protected under DC and Federal laws and rules. Your health care providers who currently have your health information must obey these laws.
	Your last month of service will be _____ (month and year)

Signature of Beneficiary or Legal Guardian (if applicable)	If Legal Guardian's Signature, print name	Date Signed
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MY HEALTH GPS PROVIDER (Must be completed in order to be processed)

☐ I discussed the *My Health GPS* program with the Beneficiary. The benefits were explained; however, he/she decided to end their participation in *My Health GPS*. **In- Person** ☐ **Via telephone** ☐

Signature of the <i>My Health GPS</i> Staff:	<i>My Health GPS</i> Care Provider:	Date Signed
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-----**FOR DHCF USE ONLY**-----





Date Form Received:	Effective Date of Withdrawal:	Date Beneficiary letter mailed:
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Appendix G

Fair Hearing Process

You have a right to file a fair hearing with the Office of Administrative Hearings or the Office of Healthcare Ombudsman and Bill of Rights. At the hearing you may represent yourself or be represented by a family member or friend or an attorney. Below is information regarding the fair hearing process:

FAIR HEARING INFORMATION

Are there other actions I can take?

Yes, you may ask for a **fair hearing** from the Office of Administrative Hearings or Office of Health Care Ombudsman. **You have 90 days from the postmark date of this letter to ask for a fair hearing.**

How do I know when the 90 days begin and end?

Look at the postmark date on the envelope in which this letter was mailed. You should count 90 days from that date. Please keep a copy of the envelope in the event there are questions about the timeliness of your request for a fair hearing.

How do I ask for a fair hearing?

You can call, write, or visit the Office of Administrative Hearings or the Office of Health Care Ombudsman to ask for a fair hearing. The contact information for the Office of Administrative Hearings and the Office of Health Care Ombudsman are:

Office of Administrative Hearings

441 4th Street, NW
Ste 450
Washington, D.C. 20001
Phone: (202) 442-9094
Fax: (202) 442-4789

Office of Health Care Ombudsman

441 4th Street, NW
Washington, D.C. 20001
Phone: (202) 724-7491
Fax: (202) 535-1216





What if I need help asking for a Fair Hearing?

If you need help asking for a fair hearing, you may be able to get free legal services from the following places:

1. **Legal Aid Society of the District of Columbia** (2 locations/1 telephone number)
(202) 628-1161

1331 H Street, N.W., Suite 350
Washington, D.C. 20005

or

1911 Martin Luther King Jr. Avenue, S.E.
Washington, D.C. 20020

2. **Neighborhood Legal Services** (2 locations/1 telephone number)
(202) 832-6577

64 New York Ave, NE
Washington, DC 20002

4609 Polk Street, NE
Washington, DC 20019

3. **University Legal Services, Protection & Advocacy Program**

220 I Street, NE, Suite 130
Washington, D.C. 20002
(202) 547-0198 (voice)
(202) 547-2657 (TTY)

What happens after I ask for a Fair Hearing?

The Office of Administrative Hearings will send you a letter which describes the hearing process and a letter with your hearing date.

In accordance with the D.C. Code 4-205.59, your services will not be suspended or terminated as long as you request the fair hearing before disenrollment date.

What happens at the Fair Hearing?

You or your representative will have the chance to argue your case before a judge.

You may bring a friend, relative, advocate, or lawyer who is not an employee of the District of Columbia to assist you at your fair hearing. You may also bring witnesses and any other documents you want to present.

For more information, please go to:

<https://dhcf.dc.gov/page/fair-hearing>





- Please circle the reason:
- ❖ Location
 - ❖ Customer Service
 - ❖ Personal Preference
 - ❖ Another known Provider
 - ❖ Other _____

MY HEALTH GPS OPT OUT FORM

TO BE COMPLETED BY/FOR MY HEALTH GPS BENEFICIARIES

This form must be completed when a beneficiary has not enrolled in the Program and decides not to participate in the Program. Please submit by secure email to myhgps@dc.gov or return to DHCF by mail: 441 4th St, NW, Suite 900 South, Washington, DC 20001.

Date _____

Name of Beneficiary:	Medicaid #
Current <i>My Health GPS</i> Program:	

Beneficiary initials or Staff to initials, if the consultation is done by phone, to signify the information has been discussed

When you do not want to participate in the <i>My Health GPS</i> program, you need to know that:	
	I have received information about the My Health GPS Program
	I have the right to opt- out without any interruptions of my other services
	I understand I can change my mind and enroll at any time, as long as, I remain eligible for the program
	I know to call this My Health Provider or DHCF if I want or need additional information about the program

_____ Beneficiary or Legal Guardian Name (Please Print)	_____ Signature	_____ Date Signed
--	--------------------	----------------------

☐ I discussed the *My Health GPS* program with the Beneficiary. The benefits were explained; however, he/she decided not to participate in My Health GPS.



In- person



Via telephone

Signature of the *My Health GPS* Staff:

Print Name of My Health GPS Staff

Date Signed

FOR DHCF USE ONLY

Date Form Received:

Date Opt-Out effective:

Date Beneficiary letter mailed:





Appendix I

My Health GPS CMS Quality Measures				
Acronym	Measure	Measure Steward (web site)	Description	Data Collection Method(s)
CMS Required Core Set				
ABA-HH	Adult Body Mass Index Assessment	NCQA/HEDIS http://www.ncqa.org	Percentage of Health Home enrollees ages 18 to 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	Administrative or hybrid
CDF-HH	Screening for Clinical Depression and Follow-Up Plan	CMS https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/index.html	Percentage of Health Home enrollees age 12 and older screened for clinical depression on the date of encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.	Hybrid or EHR
PCR-HH	Plan All-Cause Readmission Rate	NCQA/HEDIS http://www.ncqa.org	For Health Home enrollees age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	Administrative
FUH-HH	Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS http://www.ncqa.org	Percentage of discharges for Health Home enrollees age 6 and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported: Percentage of discharges for which the Health Home enrollee received follow-up within 30 days of discharge. Percentage of discharges for which the Health Home enrollee received follow-up within 7 days of discharge.	Administrative





My Health GPS CMS Quality Measures

Acronym	Measure	Measure Steward (web site)	Description	Data Collection Method(s)
CMS Required Core Set				
CBP-HH	Controlling High Blood Pressure	NCQA/HEDIS http://www.ncqa.org	Percentage of Health Home enrollees ages 18 to 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year based on the following criteria: Health Home enrollees ages 18 to 59 whose BP was <140/90 mm Hg Health Home enrollees ages 60 to 85 with a diagnosis of diabetes whose BP was <140/90 mm Hg Health Home enrollees ages 60 to 85 without a diagnosis of diabetes and whose BP was <150/90 mm Hg	Hybrid or EHR
IET-HH	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA/HEDIS http://www.ncqa.org	Percentage of Health Home enrollees age 13 and older with a new episode of alcohol or other drug (AOD) dependence who: Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis Initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	Administrative or EHR
PQI92-HH	PQI 92 Prevention Quality Chronic Condition Composite	AHRQ http://www.qualityindicators.ahrq.gov/	Number of hospital admissions for chronic conditions per 100,000 member months for Health Home enrollees age 18 and older.	Administrative





CMS Required Utilization Measures				
Acronym	Measure	Measure Steward (web site)	Description	Data Collection Method(s)
AMB-HH	Ambulatory Care— Emergency Department Visits	NCQA/HEDIS http://www.ncqa.org	Rate of emergency department (ED) visits per 1,000 enrollee months among Health Home enrollees.	Administrative
IU-HH	Inpatient Utilization	CMS https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/index.html	Rate of all acute inpatient care and services per 1,000 enrollee months among Health Home enrollees.	Administrative
NFU-HH	Nursing Facility Utilization	CMS https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/index.html	Number of admissions to a nursing facility from the community that result in a short-term (less than 101 days) or long-term stay (greater than or equal to 101 days) during the measurement year. Two rates are reported per 1,000 enrollee months: Short term admissions (less than 101 days) Long-term admissions (greater than or equal to 101 days)	Administrative





Appendix J



MY HEALTH GPS

AGGREGATE OPTION FORM

TO BE COMPLETED BY FOR MY HEALTH GPS ENTITIES/PROVIDERS

This form must be completed when two (2) My Health GPS Entities have agreed to aggregate their beneficiary population. DHCF must be notified by **September 1st** prior to each measurement year. Please submit by secure email to myhgps@dc.gov or return to DHCF by mail: 441 4th St, NW, Suite 900 South, Washington, DC 20001

Date form completed _____

(My Health GPS Entity) (#1) _____ requests to aggregate our beneficiary population with
(My Health GPS Entity) (#2) _____ beneficiary population with the purpose of
calculating the attainment or improvement on the required measures. We understand that this option shall cover all
measures during a given baseline or measurement year based on the following conditions:

Entity # 1 initial	Entity # 2 Initial	Each Entity Health Home Director's initial <i>or</i> Designated Staff to initial
		DHCF must be notified by September 1 st prior to each measurement year
		The option to aggregate will be throughout the measurement year unless one (1) Entity withdraws from the program during that measurement year.
		If either one (1) entity withdraws before the measurement year is complete, the remaining entity will be measured based on the remaining My Health GPS beneficiaries
		The My Health GPS entity shall report identifiable data for their individual performance along with the aggregated data
		Each entity may decide to opt into aggregate pooling and may change their selection on an annual basis.

#1 MHGPS Entity Health Home Director (Print)

Signature

Date

#2 MHGPS Entity Health Home Director (Print)

Signature

Date

FOR DHCF USE ONLY

Date Form Received:

Date Aggregate effective:

Date Providers notified:





Appendix K



**MY HEALTH GPS
SENTINEL EVENT FORM**

What type of event is being reported (circle one):

- ❖ Death
- ❖ Permanent Harm
- ❖ Severe Temporary Harm
- ❖ Other _____

TO BE COMPLETED FOR MY HEALTH GPS BENEFICIARIES

This form must be completed when the beneficiary has a sentinel event. Please submit by secure email to myhgps@dc.gov or return to DHCF by mail: 441 4th St, NW, Suite 900 South, Washington, DC 20001

Name of Beneficiary:	Date of Birth:	Medicaid Number:
My Health GPS Entity Provider Name:	MHGPS Staff completing this form (print):	My Health GPS Entity/Provider Telephone Number:
Date and Time (AM/PM) of Event:	Date and Time Event First Known:	Patient and/or Authorized Representative notified of event? Y/N
Describe the event including location (Include facts about the event and Patient's Condition):		
Immediate Plan of Action:		
Action Plan to prevent reoccurrence:		

Completion date for Action plan:	Identification of staff member and title, who has been designated the responsibility for monitoring CAP implementation:	Submitted by:
Name of Staff Completing Report:	Signature of Staff Completing Report:	Today's Date:

-----**For DHCF Use Only**-----

Date DHCF received

--





Appendix L

My Health GPS (Health Home II) Billing Guide

Date: 12/2018
Version: 2.01

1 CLAIMS PROCESSING PROCEDURES

In order to ensure that the DC Medicaid claim is processed according to DC Medicaid policy, an advanced Medicaid Management Information System (MMIS) has been developed to adjudicate and price claims. This chapter outlines the claims process.

1.1 Receive and Record

Claims are received by MMIS in one of two media types: paper or electronic. Paper claims are handwritten or generated by computer. Standardized forms have been developed for the submission of services for payment. Standardization ensures appropriate entry and formatting of claims. For information regarding obtaining claim forms refer to section 9.1.

DC providers have the option of billing via Web Portal, EDI (Electronic Data Interchange) or paper. WINASAP is software that has been developed by MMIS to give DC Medicaid providers the capability for accelerated submission of Medicaid claims. DC providers may also submit electronic claims by utilizing billing agents, clearinghouses, or other third-party billing software. Submitting claims electronically drastically reduce the time required for Medicaid claims to be prepared for the Medicaid Management Information System (MMIS). Electronic submission eliminates the process of document preparation, mailing, claims receipt, and data entry. Using electronic submission, claims are transmitted directly to EDI or received in electronic format, then uploaded to the MMIS the same day of receipt.

Hard copy claims are received in the mailroom where they will undergo a review process.

1.2 Review

After hard copy claims have been received, they are reviewed for essential data. If essential data is missing, the claims will be returned to the provider (RTP). A claim will be rejected if any of the following situations occur:

- Original provider signature is missing (stamped signatures are not acceptable)
- Provider Medicaid identification number is missing
- Recipient Medicaid identification number is missing
- Claim submitted on an unaccepted claim form (older claim form version). [Note: DC Medicaid accepts CMS1500 (08/05), 2006 ADA Dental, and UB04 claim forms.]
- Writing not legible





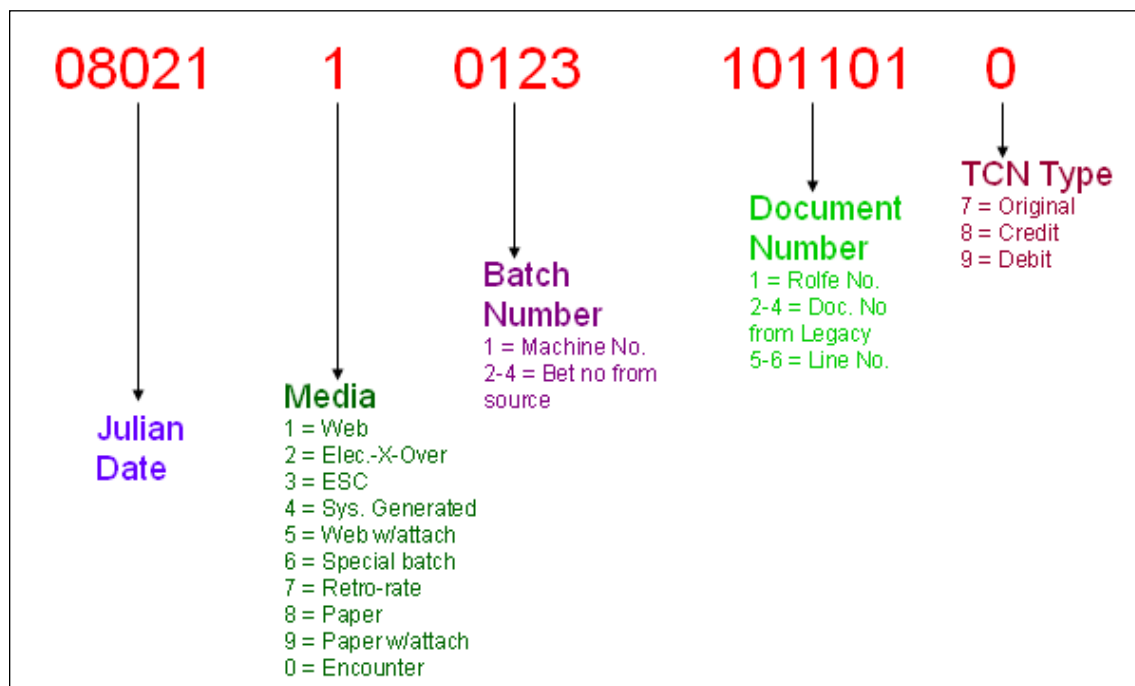
Any claim that is RTP'd will be accompanied by an RTP letter. If the claim was submitted as a paper, the original claim can be corrected. If the claim was originally submitted electronically, it can be resubmitted electronically or be transferred to paper for resubmission.

1.3 Transaction Control Number

The transaction control number (TCN) is a unique tracking number assigned to each accepted claim. Rejected claims, submitted hard copy (Refer to the above Section 8.2 for list of reasons for claim rejection reasons) or electronically are not assigned a TCN until all errors have been corrected and resubmitted. If the claim was submitted as a hard copy, the original claim can be corrected. If the claim was originally submitted electronically, it can be resubmitted electronically or transferred to paper for resubmission.

The TCN consists of 17 numeric digits. The TCN structure is as follows:

Figure 1: TCN Structure



1.4 Input

Claims that have been accepted and have received a TCN are sent to data entry. After data entry operators have keyed these claims, the MMIS starts the editing process. If edits appear, the resolutions unit then works them. Edits give operators the opportunity to correct errors. The claims are then entered into the MMIS for the processing.

1.5 Edits

When the claim data has been entered into the MMIS, it is edited to ensure compliance with the following DC Medicaid requirements:

- Provider eligibility
- Recipient eligibility





- Valid and appropriate procedure, diagnosis, and drug codes
- Reasonable charges
- Duplicate claims
- Conflicting services
- Valid dates
- Other Medicaid requirements

The status that is assigned to each claim is dependent on compliance with the requirements. The assigned status of each claim will be paid, denied, or suspended.

The Remittance Advice (RA) document sent to providers shows the status of each claim submitted by the provider and entered into the MMIS. The claims information is sorted on the RA in the following order:

- Paid original claims
- Paid adjustment claims
- Denied original claims
- Denied adjustment claims
- Suspended claims (in process)
- Paid claims MTD
- Denied claims MTD
- Adjusted claims MTD
- Paid claims YTD
- Denied claims YTD

1.5.1 Approval Notification

Claims that meet all requirements and edits are paid during the next payment cycle. The provider will receive a Remittance Advice (RA) weekly listing all paid, denied and suspended claims in the system. The provider will also receive a reimbursement check or direct deposit for paid claims. The RA will include claim amounts that have been processed and a total of all paid claims.

Claims previously paid incorrectly may be adjusted or voided. Voids will appear as credits; adjustments will appear as two transactions, debit and credit.

Adjustments/voids must be initiated by the provider since the provider can only correct errors after the claim has been paid and appears on the RA. It is the responsibility of the provider to make corrections when errors are made.

The following examples show the importance of adjusting or voiding a previously adjudicated claim on which errors have occurred:

- The provider treated John Smith, but inadvertently coded a Recipient Identification Number of Jane Smith who may or may not be the provider's patient. The provider will need to void the claim for Jane Smith and submit an original claim for John Smith giving the correct identification number.
- On the original claim the provider entered the incorrect charge for an accommodation. The provider will need to adjust (correct) the claim in order to obtain the correct reimbursement.





- The provider submits a claim in which an incorrect procedure code was used. In this case, the code was for removal of an appendix. This was not the procedure performed but the claim was paid according to the procedure listed. The provider will need to adjust (correct) this claim via an adjustment and enter the correct code for the procedure performed. This is an important step because should the patient ever require an appendectomy, that claim would otherwise be denied because the record reflects that the appendix had previously been removed.

The provider will be paid by check or direct deposit for all paid claims in accordance with current guidelines. Payments to providers may be increased or decreased by DHCF to accommodate previous overpayments, underpayments or an audit.

1.5.2 Denied

Claims that do not meet DC Medicaid edit requirements will not be paid. All denied claims are listed on the RA in alphabetical order by recipient last name. Denial reasons are listed on the RA as well. Listed below are some examples of denial reasons:

- Recipient not eligible on date of service
- Provider not eligible on date of service
- Duplicate claim
- Claims submitted more than six months from date of service (timely filing)

1.5.3 Suspended

Claims that do not meet the edit requirements cannot be paid until discrepancies have been resolved. In order to verify that the claim is in error, the MMIS assigns a status of “Suspend” which will outline the problem to resolve the issue. Claims will suspend for a variety of reasons; however, the most common reasons for claims to suspend are due to recipient eligibility, provider eligibility or the claim must be manually priced. Claims that suspend should not be re-submitted. If a second claim is submitted while the initial claim is in a suspended status, both claims will suspend. Please allow the suspended claim to be processed and to be reported on the RA as paid or denied before additional action is taken.

MMIS and DHCF resolve all pended claims. The RA will only state that the claim is suspended and will not give a reason.

1.6 Timely Filing

All services to be reimbursed must be billed on the appropriate form, signed, and submitted to MMIS or in the case of presumptive eligibility, DHCF. All hard copy claims must be mailed to their respective P.O. Box, unless otherwise instructed.

The Department of Health Care Finance (DHCF) received approval from the Department of Health & Human Services Center for Medicare and Medicaid Services (CMS) to amend the Medicaid State Plan regarding timely filing of Medicaid claims. Effective October 1, 2012, the timely filing period for Medicaid claims is 365 days from date of service.

Secondary and tertiary Medicaid claims submitted for payment must be submitted within 180 days from the payment date from Medicare or the third-party payer. The Explanation of Benefits (EOB) statement must be attached to the claim.





For claims submitted on or after October 1, 2012, DHCF will not pay any claim with a date of service that is greater than three hundred and sixty-five (365) days prior to the date of submission. All claims for services submitted after 365 days from the date of service will not be eligible for payment. In addition, the amendment outlines the following exceptions to the 365-day timely filing requirement:

- When a claim is filed for a service that has been provided to a beneficiary whose eligibility has been determined retroactively, the timely filing period begins on the date of the eligibility determination.
- Where an initial claim is submitted within the timely filing period but is denied and resubmitted subsequent to the end of the timely filing period, the resubmitted claim shall be considered timely filed provided it is received within 365 days of the denial of the initial claim.
- If a claim for payment under Medicare has been filed in a timely manner, DHCF may pay a Medicaid claim relating to the same services within 180 days of a Medicare payment.

This amendment to the State Plan applies to all DC Medicaid public, private and out of state providers who submit claims to DHCF.

To avoid denial, all hard copy and electronically submitted claims must be received within 365 days of the date of service.

1.7 Inquiries

When making written and telephone inquiries related to RA status, providers must provide MMIS with the date of the RA and the TCN for the claim in question. All written inquiries should be mailed to the Provider Inquiry P.O. Box listed in Appendix A.

2 BILLING INFORMATION

This section provides general billing information for use by providers when submitting claims.

2.1 Billing Procedures

Providers must supply their own standard claim form for the services provided or bill electronically. The following claim form is approved for filing claims utilizing the national standards for claim completion for goods or services provided to Medicaid beneficiaries for My GPS Service:

- CMS-1500

2.1.1 Form Availability

Original red CMS1500 and UB04 claim forms may be obtained from office supply stores (i.e., Staples, Office Depot, etc.) and Government Printing Office. The ADA Dental claim form must be obtained from the American Dental Association.

2.1.2 Procedure and Diagnosis Code Sources

The procedure coding system recognized by the Medicaid Program is the Health Care Financing Administration's (HCFA) Common Procedural Coding System (HCPCS) as adopted by DHCF. The HCPCS consists of current year CPT-4 codes and HCFA codes.





Diagnosis numerical coding is required based on the International Classification of Diseases, Tenth Revision, Modification (ICD-10-CM). Refer to Appendix A for address and contact information.

2.2 Electronic Billing

DC Medicaid encourages transmission of claims electronically. Currently, DC Medicaid receives claims in the following media types:

- Web Portal
- EDI
- WINASAP

The Medicaid Management Information System has implemented a Web Portal to provide tools and resources to help healthcare providers conduct their business electronically. Electronic claim submission provides for timely submission and processing of claims. It also reduces the rate of pended and denied claims.

Providers who are interested in receiving electronic billing instructions should indicate this interest on their EDI Enrollment application. Procedures specific to electronic billing are sent to providers approved to submit claims in this manner. The EDI X12N companion guides are available for download on the Web Portal. If you are already enrolled in the program and would like information on electronic claims billing, please contact MMIS directly.

2.3 Resubmission of Denied Claims

If a claim has been denied due to reasons other than violations of good medical practice or Medicaid regulations, the claim may be resubmitted. An original claim must be submitted; copies will not be accepted. Only claims, which have appeared on your remittance advice as, denied, can be resubmitted. Claims that are still in a Pend status cannot be resubmitted until they have been denied. Resubmission of a pended claim will result in claims denying for duplicate.

Telephone and/or written claim inquiries regarding non-payment of claims should be made after 45 days from the date the claims were initially submitted to DC Medicaid. Please be certain that the claim in question has not appeared on any subsequent remittance advice before making an inquiry.

Instructions for resubmitting a denied claim are as follows:

- Claims must be received within 365 days after the date of service. Claims must be resubmitted within 365 days of the RA date on which the claim denied for any reason(s) other than timely filing.
- Complete a new red claim form. A copy of the original claim form will be accepted provided that it is clear, legible and has been resigned (a copied or stamped signature will not be accepted).
- Correct any errors that caused the original claim to be denied.
- Do not write anything on the claim except what is requested. Any additional information should be submitted in writing and attached to the claim.





- Attach a copy of the Remittance Advice on which the denied claim appears and any other documentation necessary to have the claim paid (e.g., consent form, isolation form). If more than one resubmitted claim appears on a page of the remittance, a copy of that page should be attached to each claim being submitted.
- Forward all resubmitted claims to the appropriate P.O. Box listed in Appendix.

If you have any questions regarding these procedures, contact Customer Support at (866) 752-9233 (outside DC metro area) or (202) 906-8319 (inside DC metro area).

2.4 Claim Appeals

A Medicaid claim may be denied for several reasons. It could be due to services not being covered under the plan or the provider submitting a claim for a much higher amount than what Medicaid pays for the service. Providers may appeal any decision made by Medicaid, if you believe your claim was inappropriately denied. Requests for claim appeals should be sent to the address indicated in Appendix.

3. REIMBURSEMENTS

Reimbursement for services furnished by a My GPS provider shall be determined in accordance with the methodology set forth under Chapter 102 of Title 29 of the DCMR.

The following HCPCS codes and modifiers should be billed for services rendered to a *My Health GPS* beneficiary.

HH2		
HCPCS code and Description	Acuity 1 Case Management	Acuity 2 Case Management
U1- Comprehensive care management post hospitalization and significant events	T2022 – U1	T2023 – U1
U2 - Care coordination	T2022 – U2	T2023 – U2
U3 - Health promotion	T2022 – U3	T2023 – U3
U4 - Comprehensive transitional care/follow-up	T2022 – U4	T2023 – U4
U5 - Patient & family support	T2022 – U5	T2023 – U5
U6 - Referral to community & social support services	T2022 – U6	T2023 – U6
U8- New and Annual Care Plan development	T2022- U8	T2023- U8
GT- Telemedicine (only applicable when telemedicine is in use)		

Each encounter with the beneficiary must be either billed or reported monthly to DHCF.





The first claim billed each quarter will be adjudicated as PMPQ, subsequent claims will receive a denied status with a PMPQ exception code. DHCF may request for Providers to submit monthly reports as an alternative to the electronic encounters.

Providers must bill using applicable NPI and taxonomy from the approval letter. The assigned NPI and taxonomy will also be the rendering provider on the claim. This is a change for the physician groups.

3.1 Payment Inquiries

Providers may inquire regarding payment of claims. Inquiries must include the TCN, the RA payment date, the provider's DC Medicaid identification number or NPI as it appears on the provider's RA. Providers should address payment inquiries to the address listed in the Appendix. Telephone inquiries will be directed to MMIS at the number listed in the Appendix.

3.2 Telemedicine Services

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.

3.2.1 Telehealth

Under the *My Health GPS* program, approved *My Health GPS* providers may deliver *My Health GPS* services remotely. Subsequent to the initial needs' assessment, which must be conducted in-person, the *My Health GPS* program will reimburse for service delivery via audio/video/telephonic connection. These remote options (audio/video/telephonic) must include GT as a secondary modifier.

3.3 Remittance Advice

The remittance advice is a computer-generated document that displays the status of all claims submitted to the fiscal agent, along with a detailed explanation of adjudicated claims. This document is designed to permit accurate reconciliation of claim submissions. The remittance advice, which is available weekly, can be received electronically through the Web Portal.

- Mailer Page
- Header Page
- Provider Messages
- Claim Detail Report will include the following when applicable:
 - Paid/Denied Claims
 - Suspended Claims
 - Provider Adjustments/Legends





Figure 2: Remittance Advice Mailer Page

1022800000##### DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DCHF) #####PAGE: 440
MEDICAID MANAGEMENT INFORMATION SYSTEM
REMITTANCE ADVICE

[1]
PLEASE SEND INQUIRIES TO: DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DCHF)
%ACS% PROVIDER RELATIONS
P.O. BOX 34761
WASHINGTON, DC 20043-4761
TELEPHONE: (202) 906-8319 OR (866) 752-9233
WEB PORTAL: HTTP://WWW.DC-MEDICAID.COM

PHYSICIAN PRACTITIONER, M.D [2]
P.O. BOX 812300
WASHINGTON, DC, 20017 [3]

Table 1: Remittance Advice Mailer Page Table

FIELD NAME	Field #	DESCRIPTION
PLEASE SEND INQUIRES TO	1	Fiscal Agent Services Name/Address/City/State/Zip, contact phone number and the Web Portal address.
PROVIDER NAME	2	The name of the provider receiving the remittance advice
PROVIDER ADDRESS 1	3	Provider remit mailing address first address line
PROVIDER ADDRESS 2	3	Provider remit mailing address second address line
PROVIDER CITY	3	Provider Remit Mailing address city
PROVIDER STATE	3	Provider Remit Mailing address state
PROVIDER ZIP	3	Provider Remit Mailing address zip code





Figure 3: Remittance Advice Header Page

102551100000***** DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF) *****PAGE:		441
MEDICAID MANAGEMENT INFORMATION SYSTEM REMITTANCE ADVICE		
PAY TO PROVIDER NUMBER:	022800000 [1] PHYSICIAN PRACTITIONER, M.D [2] P.O. BOX 812300 WASHINGTON, DC, 20017 [3]	
(FOR CHANGE OF ADDRESS, DOWNLOAD FORM FROM WEB PORTAL) PLEASE SEND INQUIRIES TO: DISTRICT OF COLUMBIA - DHCF ACS STATE HEALTHCARE-PROVIDER RELATIONS [4] P.O. BOX 34761 WASHINGTON, DC 20043-4761 (202) 906-8319 OR (866) 752-9233 HTTP://DC-MEDICAID.COM		
PAYMENT ACCOMPANIES REMITTANCE TOTAL ASSOCIATED PAYMENT: \$177.31 [5] PAYMENT DATE: 08/03/2009 [6]		
PAID TO PROVIDER TAX ID:	123456789 [7]	
FOR CLAIMS PAID THROUGH:	08/03/2009 [8]	
PHYSICIAN PRACTITIONER, M.D P.O. BOX 812300 WASHINGTON, DC, 20017		

Table 2: Remittance Advice Header Page Table

FIELD NAME	Field #	DESCRIPTION
PAY TO PROVIDER NUMBER	1	The number of the provider or group who is to receive payment. The pay to provider is not necessarily the same as the provider who performed the service. This provider number also appears in the very top left of the header page.
PROVIDER NAME	2	The name of the provider receiving the remittance advice
PROVIDER ADDRESS 1	3	Provider remit mailing address first address line
PROVIDER ADDRESS 2	3	Provider remit mailing address second address line
PROVIDER CITY	3	Provider Remit Mailing address city
PROVIDER STATE	3	Provider Remit Mailing address state
PROVIDER ZIP	3	Provider Remit Mailing address zip code





FIELD NAME	Field #	DESCRIPTION
PLEASE SEND INQUIRES TO	4	Fiscal Agent Services Name/Address/City/State/Zip, contact phone number and the Web Portal address.
TOTAL ASSOCIATED PAYMENT	5	Total amount of the cycle check/EFT
PAYMENT DATE	6	This is the payment date of the check /EFT
PAID TO PROVIDER TAX ID	7	The federal tax ID of the provider or group who is to receive payment.
FOR CLAIMS PAID THROUGH	8	Cycle Run Date

Provider Messages

The third page of the RA, as shown below, is used to display messages from DHCF and the FA to Medicaid providers. This page is used to address changes in billing procedures or program coverage. Not all RAs will contain a message. Any information listed here will be valuable in facilitating the filing of claims to Medicaid and to provide information on the Medicaid program.

Page Header Information

The Remittance Advice will consist of three different sections: Paid/Denied Claims, Suspended Claims, and, Provider Adjustments/Legends Page. The Page Header information will be similar throughout the Remittance Advice; however, the last line in the top middle section of the RA header will indicate the specific section of the RA. The similar fields are as follows:





Figure 4: Remittance Advice Provider Messages

DATE: 08/03/09	[1]	DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCf)	PAGE: 00000003	[5]
PROVIDER NO: 022222222	[2]	MEDICAID MANAGEMENT INFORMATION SYSTEM	RPT PAGE: 000000442	[6]
REMITTANCE: 00438970	[3]	REMITTANCE ADVICE	REMIT SEQ: 00000054	[7]
NPI NUMBER: 130000000	[4]	PROVIDER MESSAGES		

This is a test message.				

Table 3: Remittance Advice Provider Messages Table

FIELD NAME	Field #	DESCRIPTION
DATE	1	This is the process date used for reporting purposes
PROVIDER NO	2	The number of the provider or group who is to receive payment. The pay to provider is not necessarily the same as the provider who performed the service.
REMITTANCE	3	The remittance advice number uniquely identifies the remittance Advice prepared for this provider for a given payment cycle.
NPI NUMBER	4	The pay to provider's National Provider Identifier (NPI)
PAGE	5	Page number within each provider's report
RPT PAGE	6	Page number across all provider's reports
REMIT SEQ	7	Sequential number produced for this RA cycle

Claim Detail Report - Paid/Denied Claims

Paid claims are line items passing final adjudication. Claims may be paid as submitted or at reduced amounts according to the Medicaid program's reimbursement methodology. Reduced payments will be noted on the RA with the corresponding edit code for explanation.

Denied claims represent those services that are unacceptable for payment. Denials may occur if the fiscal agent cannot validate claim information, if the billed service is not a program benefit, or if a line item fails the edit/audit process. Denied claims may be reconsidered for payment if a health care provider





submits corrected or additional claim information. Services denied on the RA appear on one line. A service may be reconsidered for payment if errors were made in submitting or processing the original claim.

Figure 5: Remittance Advice Paid Claims

DATE: 10/08/09 DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF) PAGE: 00000005
 PROVIDER NO: [REDACTED] MEDICAID MANAGEMENT INFORMATION SYSTEM RPT PAGE: 000000030
 REMITTANCE: 00438277 REMITANCE ADVISE REMIT SEQ: 00000006
 NPI NUMBER: [REDACTED] ADJUSTMENTS PAID PRACTITIONER/PHYSICIAN

RECIPIENT NAME	MEDICAID ID	TCN	PAT ACCT NUM	MED REC NO
09/24/09-09/24/09 11	[REDACTED]	09279100010000018		
REF: ORIGINAL TCN: 092681000100000147	DRG CODE:	DRG WEIGHT:	0.00000	
1 99213 HC/HCP/CS/CPT CODE				
09/24/09-09/24/09	-1.00	-50.00	.00	-50.00 CREDIT
09/24/09-09/24/09 11	[REDACTED]	09279100010000019		
REF: ORIGINAL TCN: 092681000100000147	DRG CODE:	DRG WEIGHT:	0.00000	
1 99213 HC/HCP/CS/CPT CODE				
09/24/09-09/24/09	1.00	40.00	.00	40.00 DEBIT

--- END OF ADJ PAID CLAIMS FOR PROVIDER [REDACTED] ---

Table 4: Remittance Advice Paid Claims Table

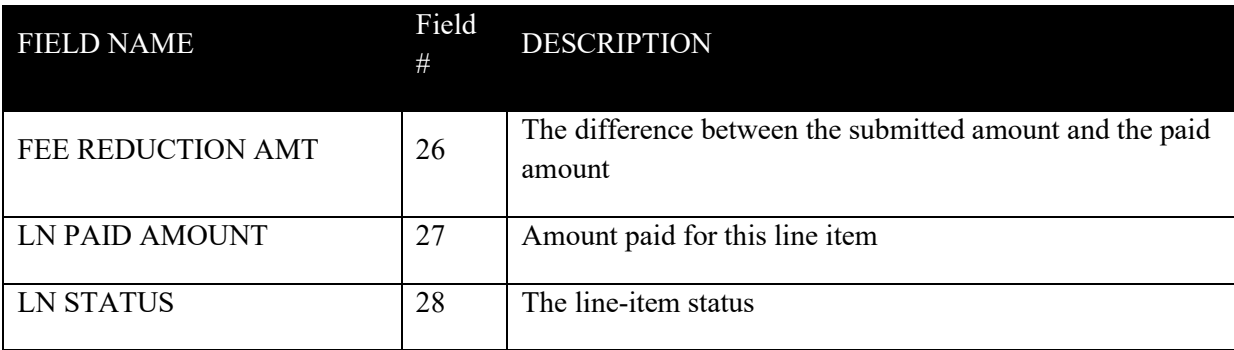
FIELD NAME	Field #	DESCRIPTION
RECIPIENT NAME	1	Patient name
MEDICAID ID	2	Medicaid's recipient ID for this patient
TCN	3	Transaction control number uniquely identifies the claim
PAT ACCT NUM	4	Patient account number as indicated on the claim by the provider
MED REC NO	5	The submitting provider's medical record number as referencing this claim. This number is printed on the RA to assist providers in identifying the patient for whom the service was rendered.
DATES OF SERV	6	First and last dates of service for this claim





FIELD NAME	Field #	DESCRIPTION
TOB	7	Type of bill. Depending on the type of claim submitted, the code will either be the facility type code or place of service code.
SVC PVDR	8	Servicing provider ID
SVC PVDR NAME	9	Servicing provider name
SUBMITTED AMT	10	Total charges submitted for this TCN
FEE REDUCTION AMT	11	The difference between the submitted amount and the paid amount
PAT RESP AMT	12	Amount payable by patient
TOT PAID AMT	13	Total amount paid on this TCN. (For balancing, this should equal Submitted Charges Minus Adjustments.)
STATUS	14	Claim Status (Paid – Denied – Suspended)
LINE	15	The line-item number on the claim
PROC	16	The line-item procedure code if applicable.
TYPE/DESC	17	The type of code listed in the procedure code (PROC) field.
M1, M2, M3, M4	18	The procedure code modifiers.
REVCD	19	The line-item revenue code if applicable.
THCD	20	The tooth code if applicable.
SVC PROV	21	The line-item servicing provider ID
PROV CONTROL NO	22	The line-item control number submitted in the 837 which is utilized by the provider for tracking purposes. (REF02 qualifier 6R in 835)
DATES OF SERV	23	First and last dates of service for this line item
LINE UNITS	24	Number of units
LN SUBM AMOUNT	25	The line item submitted amount.



[illegible]

Field Name	Description
RECIPIENT NAME	Patient name
MEDICAID ID	Medicaid's recipient ID for this patient



Field Name	Description
TCN	Transaction Control Number that uniquely identifies the claim
PAT ACCT NUM	Patient Account number
MED REC NO	The submitting provider's medical record number as referencing this claim
DATES OF SERV	First and last dates of service for this claim
TOB	Type of bill
SVC PVDR	Servicing provider ID
SVC PVDR NAME	Servicing provider name
SUBMITTED AMT	Total charges submitted for this TCN
FEE REDUCTION AMT	The difference between the submitted amount and the paid amount
PAT RESP AMT	Amount payable by patient
TOT PAID AMT	Total amount paid on this TCN. (For balancing, this should equal Submitted Charges Minus Adjustments.)
STATUS	Claim Status (Paid – Denied – Suspended)
LINE	The line-item number on the claim
PROC	The line-item procedure code if applicable.
TYPE/DESC	The type of code listed in the PROC field.
M1, M2, M3, M4	The procedure code modifiers.
REVCD	The line-item revenue code if applicable.
THCD	The tooth code if applicable.
SVC PROV	The line-item Servicing provider ID
PROV CONTROL NO	The line-item control number submitted in the 837 which is utilized by the provider for tracking purposes. (REF02 qualifier 6R in 835)
DATES OF SERV	First and last dates of service for this line item
LINE UNITS	Number of units
LN SUBM AMOUNT	The line item submitted amount.





Field Name	Description
FEE REDUCTION AMT	The difference between the submitted amount and the paid amount
LN PAID AMOUNT	Amount paid for this line item
LN STATUS	The line-item status
REF : ORIGINAL TCN	The TCN that is being adjusted.
DRG CODE	DRG Code. (Not currently used).
DRG WEIGHT	DRG Weight. (Not currently used).
EXCEPTION CODES	The line-item exception codes
EXPLANATION OF BENEFITS CODES (EOB)	The line-item EOB codes

Figure 7: Remittance Advice Suspended Claims

DATE: 09/07/09		DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCf)							PAGE: 00000004								
PROVIDER NO: 019999999		MEDICAID MANAGEMENT INFORMATION SYSTEM							RPT PAGE: 000001761								
REMITTANCE: 00441451		REMITTANCE ADVICE							REMIT SEQ: 00000168								
NPI NUMBER: X1999999998		SUSPENDED CLAIMS			INPATIENT												
=====																	
RECIPIENT NAME		MEDICAID ID		TCN		PAT ACCT NO			MED REC NO								
DATES OF SERV		STAT DT		TOB		SVC PVDR		SVC PRV NAME		DRG CODE		DRG WEIGHT		TOTAL SUBMITTED		STATUS	
LN DATES OF SERVICE		SVC PVDR		PROC		TYPE/DESC				M1 M2 M3 M4 REVCD		THCD		UNITS		SUBMITTED	
=====																	
RECIPIENT SAMPLE		709999999		09163800030000077													
04/10/09-04/12/09		07/01/09		111		019999999		CAPITOL D.C. NURSING CENTER				0.00000		900.00		PEND	
EXCEPTION CODES: 0182 0303 0313 0381 1334 5209 5302																	
1 04/10/09-04/12/09		019999999				NU/NUBC UB92 CODE				0121		2.00		500.00			
2 04/10/09-04/12/09		019999999		X0072		HC/HCPCS/CPT CODE				0682		4.00		400.00			
--- END OF PENDED CLAIMS FOR PROVIDER 019999999 ---																	

Table 6: Remittance Advice Suspended Claims Table

FIELD NAME	DESCRIPTION
RECIPIENT NAME	Patient name
MEDICAID ID	Medicaid's recipient ID for this patient





FIELD NAME	DESCRIPTION
TCN	Transaction Control Number that uniquely identifies the claim
PAT ACCT NO	Patient account number as indicated on the claim by the provider
MED REC NO	The submitting provider's medical record number as referencing this claim
DATES OF SERV	First and last dates of service for this claim
STATUS DT	Date the claim was suspended (generally the cycle date)
TOB	Type of bill
SVC PVDR	Servicing provider ID
SVC PVDR NAME	Servicing provider name.
DRG CODE	DRG Code. (Not currently used).
DRG WEIGHT	DRG Weight. (Not currently used).
TOTAL SUBMITTED	Total charges submitted for this TCN
STATUS	The overall claim status.
LN	The line item number on the claim
DATES OF SERVICE	First and last dates of service for this line item
SVC PVDR	The line item servicing provider ID
PROC	The line item procedure code if applicable
TYPE/DESC	The type of code listed in the procedure code (PROC) field
M1, M2, M3, M4	The procedure code modifiers.
REVCD	The line item revenue code if applicable.
THCD	The tooth code if applicable.
UNITS	Number of units
SUBMITTED	The line item submitted amount.
EXCEPTION CODES	The exception codes that are posted to the header level or the line item.





Figure 8: Remittance Advice Provider Totals/Legend

DATE: 09/07/09	DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF)	PAGE: 00000005
PROVIDER NO: 02700000	MEDICAID MANAGEMENT INFORMATION SYSTEM	RPT PAGE: 000000680
REMITTANCE: 00441326	REMITTANCE ADVICE	REMIT SEQ: 00000077
NPI NUMBER: 18000797148	PROVIDER TOTALS/LEGEND	

CLAIM TOTALS	-----STATUS-----	---COUNT---	--SUBMITTED AMT--	-----PAID AMT----
	ORIGINAL PAID	0	0.00	0.00
	CREDIT ADJUSTMENTS	1	41.00-	5.00-
	DEBIT ADJUSTMENTS	1	41.00	5.00
	VOIDS	0	0.00	0.00
	=====	=====	=====	=====
	APPROVED SUBTOTAL		0.00	0.00
	SUSPENDED	0	0.00	
	DENIED	0	0.00	
	=====	=====	=====	=====
	CLAIM PROCESSED TOTAL		0.00	0.00
	PROVIDER FINANCIALS			0.00
	=====	=====	=====	=====
	PAYMENT TOTAL			0.00

OUTSTANDING CREDIT BALANCE AS OF 09/07/2009	0.00	
TOTAL HISTORY ONLY FINANCIAL TRANSACTIONS COUNT:	0	0.00
TOTAL HISTORY ONLY CLAIMS COUNT:	0	0.00

ADJUSTMENT SUBTOTALS	-FIRST QUARTER--	-SECOND QUARTER--	--THIRD QUARTER--	-FOURTH QUARTER--
CREDIT ADJUSTMENTS 09	0.00	0.00	5.00-	0.00
DEBIT ADJUSTMENTS 09	0.00	0.00	5.00	0.00

ONOTE: FOR REMITTANCE ADVICES OVER 100 PAGES, ONLY THE FIRST PAGE AND THE PROVIDER TOTALS PAGE WILL BE MAILED. PLEASE CONTACT (202) 906-8319 OR (866) 752-9233 TO REQUEST A COPY OF THE ENTIRE REMITTANCE ADVICE IN A CD.

0--- END OF REMITTANCE FOR PROVIDER 027332900 ---

Table 7: Remittance Advice Provider Totals/Legend Table

FIELD NAME	DESCRIPTION
CLAIM TOTALS	Totals for all categories of the RA.
STATUS	The claim status header within claim totals
COUNT	The total claim count specific to the category
SUBMITTED AMT	The total amount submitted by the provider
PAID AMT	The total paid amount.
ORIGINAL PAID	New claims submitted for this cycle
CREDIT ADJUSTMENTS	The total amount of credit adjustments
DEBIT ADJUSTMENTS	The total amount of debit adjustments
VOIDS	Total number of voided claims
APPROVED SUBTOTAL	Subtotal of approved claims





FIELD NAME	DESCRIPTION
SUSPENDED	Total number of suspended claims and charges
DENIED	Total number of denied claims and charges
CLAIM PROCESSED TOTAL	Total of submitted and paid amounts
PROVIDER FINANCIALS	
PAYMENT TOTAL	Total provider payment
OUTSTANDING CREDIT BALANCE AS OF	The outstanding credit balances.
TOTAL HISTORY ONLY FINANCIAL TRANSACTIONS	
TOTAL HISTORY ONLY CLAIMS	
ADJUSTMENT SUBTOTALS	
CREDIT ADJUSTMENTS	
DEBIT ADJUSTMENTS	
FIRST QUARTER	The total amount of adjustments and/or voids for the first quarter (Jan – Mar) in the calendar year.
SECOND QUARTER	The total amount of adjustments and/or voids for the second quarter (Apr – June) in the calendar year.
THIRD QUARTER	The total amount of adjustments and/or voids for the third quarter (July – Sept) in the calendar year.
FOURTH QUARTER	The total amount of adjustments and/or voids for the fourth quarter (Oct – Dec) in the calendar year.
EXCEPTION LEGEND	Full description of any exception codes (denial reason codes) listed on this RA
EOB CODE LEGEND	Full description of any explanation of benefit codes listed on this RA





3.3.1 Instructions for Submitting Adjustments and Voids of Claims

An Adjustment/Void claim is submitted when the original paid claim was filed or adjudicated incorrectly. Denied claims cannot be adjusted. All adjustment claims must be filed within 365 days of the date of payment.

Adjustments and voids can be submitted by paper or electronically using the Web Portal, WINASAP or third-party software. Refer to the Web Portal Claims Submission Reference Manual or the WINASAP Provider Training Manual for submitting adjustment and voids electronically.

To indicate an adjustment or voided claim, the following information must be recorded in the top right-hand corner of the claim form:

<u>Code</u>	<u>Definition</u>
-------------	-------------------

A	Adjustment
---	------------

-or-

V	Void
---	------

-and-

TCN 17-digit Transaction Control Number

Using the claim form, the provider must indicate whether the claim is being adjusted by writing the letter “A” in the top left-hand corner of the form. If the claim is being voided, the provider must indicate such by writing the letter “V” in the top left-hand corner of the form. The 17-digit TCN of the current paid claim is to be included at the top right-hand corner of both adjustments and voided claim forms.

Note: All adjustments and voids submitted on a CMS-1500 must contain an original signature. Signature stamps and/or typed names are not acceptable.

3.3.2 Post NPI Adjustments and Voids

When submitting an adjustment for a previously paid claim that processed under your Medicaid provider ID, you must submit your adjusted claim in the same manner.

Use the CMS1500 (version 08/05) form

Indicate the letter “A” for adjustment, the Transaction Control Number of the current paid claim followed by the appropriate adjustment reason code. Refer below for proper placement of the TCN and adjustment code.

- CMS1500 form: Enter the TCN and adjustment code in the top left corner.
- UB04: Enter the TCN and adjustment code in the Remarks field locator 80.
- If completing the CMS1500, enter the billing provider’s Medicaid provider ID in field 33B.





When submitting an adjustment for a previously paid claim that processed under your NPI, you must submit your adjusted claim in the same manner.

- Use the CMS1500 (version 08/05).
- Indicate the letter “A” for adjustment, the Transaction Control Number of the current paid claim followed by the appropriate adjustment reason code. Refer below for proper placement of the TCN and adjustment code.
- CMS1500: Enter the TCN and adjustment code in the top left corner.
- If completing the CMS1500, enter the billing address including the +4 zip code of the pay-to-provider in field 33; in field 33A enter the pay-to-provider’s NPI, and the pay-to-provider’s taxonomy code in field 33B.

When submitting a void for a previously paid claim that processed under your Medicaid provider ID, you must submit your voided claim in the same manner.

- Use the CMS1500 form.
- Indicate the letter “V” for void, the Transaction Control Number of the current paid claim followed by the appropriate adjustment reason code. Refer to the list below for the correct placement of the TCN and adjustment code.
- CMS1500 and Dental: Enter the TCN and adjustment code in the top left corner.
- If completing the CMS1500, enter the billing provider’s Medicaid provider ID in field 33B.

When submitting a void for a previously paid claim that processed under your NPI number, you must submit your adjusted claim in the same manner.

Use the CMS1500 claim form.

- Indicate the letter “V” for void, the Transaction Control Number of the current paid claim followed by the appropriate adjustment reason code. Refer to the list below for the correct placement of the TCN and adjustment code.
- CMS1500I: Enter the TCN and adjustment code in the top left corner.
- UB04: Enter the TCN and adjustment code in the Remarks field locator 80.
- If completing the CMS1500, enter the billing address including the +4 zip code of the pay-to-provider in field 33, enter the pay-to-provider’s NPI in field 33A and taxonomy code in field 33B.





Table 8: Adjustment/Void Codes

011	RETRO RATE CHG / NO CUTBACK
014	PROV CLAIM FILING CORRECTION
019	POS PROV FILE CORR/LEGAL SETT
022	FISCAL AGENT CLM PROCESS ERROR
068	PROVIDER REFUND/CLM OVERPAYMNT
069	PROV RFND/OVERPAY FISC ERROR
070	PROV REFUND FOR HEALTH INSUR
071	PROV REFUND FOR CASUALTY INS
081	PROV CLAIM CORR/CLM FILED ERR
082	CLM VOID/FISC AGENT PROC ERROR
083	CLM VD/PD IN ERROR/RCP INCORRE
084	CLM VD/PD ERROR/PROV FIL INCOR
085	CLM VD/PD ERROR/INCORRECT PROV
086	CLAIM VOID MEDICARE RECOVERY
088	REFUND - PROVIDER ERROR
089	REFUND- FISCAL AGENT ERROR
090	PROV RTRN CHK/PD FOR INC BENE
099	PROV RETURN CHK/ INCORR PROV
101	VOID PAYMENT TO PIP HOSPITAL
102	ACCOMMODATION CHARGE CORRECT
103	PATIENT PAYMENT AMT CHANGED
104	PROCEDURE SERVICE DATES FIX
105	CORRECTING DIAGNOSIS CODE





106	CORRECTING CHARGES
107	UNIT VISIT STUDIES PRCD FIX
108	RECONSIDERATION OF ALLOWANCE
109	FIX ADMIT REFER PRESC PROVIDER
110	CORRECTING TOOTH CODE
111	CORRECTING SITE CODE
112	CORRECT TRANSPORTATION DATA
113	INPATIENT DRG
114	ADJUSTING PATIENT LEVEL CARE
115	RECOVERY BASED ON PRO REVIEW
116	ADJUSTED FOR RECP BEDHOLD DAYS
117	MANUAL CAPITATION VOID CLAIMS
118	REPROCESSED CLAIMS
119	AUTO RECOUPMENT SYSTEM ERROR
120	AUTO RECOUPMENT SYSTEM CHANG
121	PCG SERVICES
132	CLM VD/PROV SELF-IDENT FRAUD
300	BENEFICIARY DECEASED





ADDRESS AND TELEPHONE NUMBER DIRECTORY

Always check the Department of Healthcare Finance's Website for updates

Appeal Notification

Department of Health Care Finance
One Judiciary Square
441 4th Street NW Suite 1000S
Washington, DC 20001
Attention: Appeal Unit

CPT-4 Coding Information
American Medical Association
100 Enterprise Place
P.O. Box 7046
Dover, Delaware 19903-7046

Claims Appeal – Claims Past Timely Filing MMIS

District Medicaid Claims Processing Fiscal Agent
P.O. Box 34734
Washington, DC 20043
Attention: Timely Filing Claims Appeal

Electronic Claims Submission/Electronic RA
Information
EDI (Electronic Data Interchange) – (866) 775-8563

Eligibility Determination Information
Economic Security Administration - (202) 724-5506
Inquiry Recertifications - (202) 727-5355
Fax Request - (202) 724-2041

Claim Status Information/Claims Payment Information

MMIS
District Medicaid Claims Processing Fiscal Agent
P.O. Box 34734
Washington, DC 20043
Attention: Provider Inquiry Unit

Eligibility Verification
Interactive Voice Response System (IVR) (see
Appendix B)-(202) 906-8319

Fraud Hotline-(877) 632-2873

Telephone Numbers:

(866) 752-9233 (outside DC metro area)
(202) 906-8319 (inside DC metro area)

General Program Information
Department of Health Care Finance
One Judiciary Square
441 4th Street NW Suite 1000S
Washington, DC 20001
Telephone Number - (202) 698-2000
www.dc-medicaid.com

Claim Submission Information - Mail For CMS-1500s: MMIS

District Medicaid Claims Processing
P. O. Box 34768
Washington, DC 20043

ICD-10-CM Orders
MEDICODE
5225 Post Way
Suite 500
Salt Lake City, Utah 84116
Telephone – (800) 999-4600

For Adjustments and Voids: MMIS

District Medicaid Claims Processing
P. O. Box 33458
Washington, DC 20033

DC Medicaid Pharmacy Benefits Management
Technical Call Center: (800) 272-9679
Clinical Call Center (Prior Authorizations): (800)
273-4962
PBM Fax Number: (866) 535-7622
<http://www.dc-pbm.com>

Telephone Inquiries

MMIS Provider Inquiry Unit
(866) 752-9233 (outside DC metro area)
(202) 906-8319 (inside DC metro area)





Medicaid Payment Schedule Information
MMIS, Inc.

Provider Inquiry Unit
P.O. Box 34743
Washington, DC 200043
Telephone Numbers
(866) 752-9233 (outside the District of Columbia)
(202) 906-8319 (inside the District of Columbia)

Pharmacy Consultant
Department of Health Care Finance
One Judiciary Square
441 4th Street NW Suite 1000S
Washington, DC 20001
Telephone Numbers
(202) 442-9078 or (202) 442-9076

Prior Authorization Form Submission
Qualis Health
Prior Authorization Unit: (800) 251-8890
Fax number: (800) 731-2314
Email: providerportalhelp@qualishealth.org

Provider Enrollment Information
MAXIMUS
Provider Enrollment Unit
P.O. Box 34086
Washington, DC 20043-9997

Telephone Number
(866) 218-9700
www.dcpdms.com

Transportation Broker
Medicaid Transportation Management, Inc. (MTM)
Telephone Number - (888) 561-8747
www.mtm-inc.net





IVR INSTRUCTIONS

The Bureau of Eligibility Determination, Economic Security Administration (ESA) determines eligibility for the DC Medicaid Program.

Providers should verify the beneficiary's name and identification number, effective dates of eligibility, services restricted to specified providers, and whether other insurance is on file (commonly referred to as third party liability) before rendering services.

Beneficiary eligibility may be verified by calling the Interactive Voice Response System (IVR) using a touch-tone telephone and entering the beneficiary identification number found on the beneficiary's Medical Assistance ID card. The IVR is available 24 hours a day, seven days a week with unlimited number inquiries being performed per call. The IVR may be used up to 30 minutes per call. Providers should also have their DC Medicaid provider number or NPI number ready.

To access the District of Columbia Government Medicaid IVR, dial (202) 906-8319 (inside DC Metro area) or (866) 752-9233 (outside DC Metro area) from your touch-tone phone. Select one of the following options listed below and follow the prompts. The system will prompt you to enter your nine-digit Medicaid provider number or 10-digit National Provider Identifier (NPI) followed by the pound (#) key.

- Press 1 - To verify beneficiary eligibility and claims status.
- Press 2 - If you are a new provider and would like to enroll or if you are changing your provider number.
- Press 3 - For EDI Technical Support Services
- Press 4 - For all other questions

Once you have concluded your inquiries, record the confirmation number provided at the end of the call.





APPENDIX M:
FREQUENTLY ASKED QUESTIONS

Issue	Question	Response
Assessment		
1	How should we treat recently collected clinical data, such as screens that we may have recorded in the chart from a recent visit? Is there a lookback period that we are permitted to use?	Overall, we don't want to ask you to duplicate assessments. DHCF expects that you adhere to the clinical standards and guidance for the particular assessment
2	How often does an assessment have to be done?	The Biopsychosocial Assessment is done on enrollment and annually. Additional assessments during the year are completed depending on the needs and status of the beneficiary.
3	Can I request a beneficiary go from a higher acuity to a lower acuity as well?	Yes, follow the acuity redetermination process.
4	Once I obtain consent from a beneficiary, are they enrolled?	No, a beneficiary is not enrolled until they have been consented, a service is provided, and that service is billed and paid.
Attribution		
1	How will new patients be eligible for attribution?	After the initial attribution, there is one annual attribution. If a beneficiary does not have a prior relationship with a HH provider, the beneficiary will be assigned based on geography and/or provider capacity.
2	What will happen if a patient of ours does not appear on our attribution list, but is our patient and meets the eligibility criteria?	If a beneficiary meets criteria between reviews the beneficiary or provider may submit a referral request to DHCF by following the process outlined in the manual.
3	What happens if a beneficiary wants to move to another <i>My Health GPS</i> provider?	Beneficiaries have freedom of choice and can switch providers. The provider change form should be completed by the current MHGPS provider and the receiving provider. Once the completed form is received by DHCF, the provider change will be completed. All parties will be notified.
5	Can a beneficiary choose a provider – “self-assign” – if they have changed providers after attribution?	Yes, the beneficiary can always switch providers using the Provider Change form.
6	Is there still a pre-enrollment status?	No. That status was interim during the launch of the program to identify/forecast the potential enrollment





FREQUENTLY ASKED QUESTIONS

Issue	Question	Response
		numbers. Beneficiaries are now either enrolled or not enrolled.
Billing		
1	If a provider is submitting a <i>MyHealthGPS</i> claim for an MCO beneficiary and delivers a medical service on the same day, does the provider send one claim to the MCO and one claim to DHCF?	Yes, these are separate services and programs
2	How often can I be paid for the care plan enhanced payment ?	Every 12 months
3	Do I have to bill for every MHGPS service I provide?	No, Providers only receive per member per quarter reimbursement.
4	Do I use the U8 for a post hospitalization update of the care plan during the year?	No. The U1 should be used for routine care plan updates and the U8 is reserved for the initial and annual care planning process.
5	What do the denials mean when I submit for all MHGPS services?	Denials for this program will fall under to categories: 1) The provider has already been reimbursed for the quarter 2) Errors and issues were identified with the submitted claim
6	If an eligible beneficiary is hospitalized, can an MHGPS assessment/care plan with a signed consent be completed and a U8 Modifier used to bill during this enrollment	No, if the beneficiary is hospitalized. The MHGPS team may coordinate with the beneficiary and the hospital to visit prior to their hospital discharge. The MHGPS assessment and care plan can be done only after the person is discharged.
Care Plan		
1	Many our MHGPS patients are already in the care of nurse care manager. Would it be acceptable to continue a care plan in person as opposed to starting a new one?	The new provider can benefit from the existing information but will still need to meet the established care plan requirements for a new beneficiary. The information should be incorporated into the care plan.
2	Can anyone on the approved care team initiate the new care plan or does it have to be an RN care manager?	Per the SPA, "Many activities of this HH component may be provided by any HH team member but are driven by protocols and guidelines developed by the Nurse Care Manager or comparable health care professional." All team members would work within the scope of their license and practice.
3	Is the care plan good for 11 or 12 months?	The care plan is good for 12 months therefore, if an initial was done in May the new care plan should be completed within the quarter of the 12-month period.





FREQUENTLY ASKED QUESTIONS

Issue	Question	Response
4	How should care plans be charted for MHGPS? Will it be acceptable to DCHF to have elements of the care plan "living" in different places in the EMR (or an add-on care planning module that may be purchased) or does DCHF wish to have all the elements in a stand-alone "document"?	The care plan will need to be in one place since provider is required to provide a copy to the beneficiary. The assessment(s) will need to be documented and DCHF will need to see that all required assessment fields were conducted, but the assessment information can live elsewhere in the EHR.
Consent		
1	<i>My Health GPS</i> has been described as an opt-out program. Why is consent required?	CMS requires consent
MCOs		
1	Are providers paid differently, if the beneficiary is FFS or MCO?	DCHF pays the same rate directly to <i>My Health GPS</i> providers for all <i>My Health GPS</i> beneficiaries.
NCQA		
1	What is the required timeline for receiving NCQA Level 2 PCMH recognition?	<i>My Health GPS</i> providers must achieve Level 2 recognition, or future NCQA PCMH equivalent level recognition, within 12 months of the date of submission of the <i>My Health GPS</i> application.
Outreach		
1	What is deemed eligible activities for outreach activities required in the first two quarters of assignment?	Active and progressive attempts at beneficiary engagement, including direct communication (i.e. face to face, mail, email, telephone). The provider must document: (a) The date and time of the activity; (b) Identify team member who performed the activity; (c) Note the setting; and (d) Note further action required for the beneficiary's well-being.
Staffing Model		
1	What is the best way to propose an alternative staffing model?	DCHF suggests reaching out to informally to discuss the alternative staffing model. Key principles we will look for with the alternative proposal are: Is the alternative clinically equivalent (including level of FTE effort) to the pre-approved team; is the alternative actuarially equivalent to the pre-approved team; and how does the alternative fit into the entity's workflow.
Telehealth		
1	How can telemedicine be used in the <i>My Health GPS</i> program?	Providers may deliver <i>My Health GPS</i> services remotely and use telemedicine.
2	Is there a difference between “in-person” and “face-to-face”?	Yes, in-person indicates that the provider and beneficiary are in the same physical location. Face-to-face does not require the provider and beneficiary to be in the same physical location.





FREQUENTLY ASKED QUESTIONS

Issue	Question	Response
3	Does DHCF require a synchronous discussion between patient and GPS team member (e.g. substantive messages, with instructions for the patient or an update for the patient)?	Yes, if you document the substantive exchange and that the <i>My Health GPS</i> service was completed (and, of course, a care plan has been developed).
4	How do I indicate that I used telehealth with my MHGPS service?	The GT modifier should be added as a second modifier to the claim/service.

