

DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02 (2016 Repl. & 2018 Supp.)) and Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2018 Repl.)), hereby gives notice of the adoption of an amendment to Chapter 102 (*My Health GPS* Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

The *My Health GPS* program was established as a Health Home program under the authority of Section 1945 of the Social Security Act for District Medicaid beneficiaries who have three (3) or more chronic conditions. The *My Health GPS* program was developed to address the unmet care management needs of Medicaid beneficiaries with multiple chronic conditions. In order to meet the healthcare needs of this vulnerable population, the comprehensive care management services offered through the *My Health GPS* program are delivered by an interdisciplinary team embedded in the primary care setting, that coordinates patient-centered and population-focused care for these beneficiaries.

DHCF is amending Section 10207 to establish a third PMPM rate that *My Health GPS* entities can claim for the months when the *My Health GPS* entity either develops the initial care plan or completes an annual update of the care plan. The third PMPM will support the increased level of effort required of *My Health GPS* entities to develop or annually evaluate and revise the person-centered care plan.

In addition, DHCF is amending the beneficiary risk stratification process set forth in Section 10207. Under the current process, DHCF uses a nationally-recognized risk stratification tool to determine the acuity of *My Health GPS* enrollees. DHCF has observed that using the risk stratification tool alone is not capturing all of the highest acuity, high-need, beneficiaries for inclusion in the higher acuity Group Two. Therefore, DHCF is proposing to amend Section 10207 to consider additional criteria, as outlined in published policy guidance that will ensure *My Health GPS* beneficiaries are appropriately assigned.

DHCF is also amending Section 10209 to delay implementation of the pay-for-performance program. Under the revised timeframe, DHCF will begin awarding performance payments in fiscal year (FY) 2021 based on a *My Health GPS* entity's performance in FY 2020. DHCF is changing the quality measures set forth in Section 10209. The Centers for Medicare and Medicaid Services (CMS) have retired the Timely Transmission of Transition Record measure, so DHCF is updating the rulemaking to reflect that change. DHCF is also removing the Medication Reconciliation measure due to complications in the development of the Electronic Clinical Quality Measurement Tool.

DHCF is amending Section 10206 to explicitly include the provision of support to children transitioning from a pediatric practice to an adult practice, as an activity under the Care Coordination service.

In addition, DHCF is amending the beneficiary assignment timeframe set forth in Subsection 10202.3. Currently, eligible beneficiaries who enter the program are assigned to a *My Health GPS* entity on a quarterly basis or within thirty (30) days of receipt of a referral. DHCF is proposing amendments to assign beneficiaries entering the program on a time-basis established in accordance with guidance published to the DHCF website.

The aggregate fiscal impact of the changes is a decrease in Medicaid expenditures of \$ 3,910,658 in FY 2019 and a decrease of \$ 2,512,424 in FY 2020.

These rules correspond to a related State Plan amendment (SPA), which was approved by CMS on December 31, 2018, with an effective date of December 1, 2018. A Notice of Emergency and Proposed Rulemaking was published in the *D.C. Register* on November 23, 2018 at 65 DCR 013078. No comments were received. DHCF is proposing two technical changes to this rulemaking. Subsection 10207.2 is amended to clarify that these rules are effective for services delivered on or after December 1, 2018. Subsection 10208.1(a) is amended to correct the link where information on the CMS “Core Set of Health Care Quality Measures for Health Home Programs” is located.

This rule was adopted on April 17, 2019 and shall become effective upon publication in the *D.C. Register*.

10200 GENERAL PROVISIONS

10200.1 The purpose of this chapter is to establish standards governing Medicaid reimbursement for Health Home services provided to District Medicaid beneficiaries with multiple chronic conditions. This program shall be known as the “*My Health GPS*” program.

10200.2 The goal of the *My Health GPS* program is to improve the integration of medical and behavioral health, community supports and social services, and is designed to result in the following outcomes for eligible beneficiaries:

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

10200.3 Services offered through the *My Health GPS* program shall be consistent with, but not limited to, those described under 42 CFR § 440.169(d).

10201 ELIGIBILITY CRITERIA

10201.1 Except as set forth in § 10201.2, a Medicaid beneficiary shall be eligible to participate in the *My Health GPS* program if the beneficiary has current diagnoses of three (3) or more of the following chronic conditions:

- (a) Asthma;
- (b) Body Mass Index higher than thirty-five (35);
- (c) Cerebrovascular disease;
- (d) Chronic obstructive pulmonary disease;
- (e) Chronic renal failure, indicated by dialysis treatment;
- (f) Diabetes;
- (g) Heart disease including:
 - (1) Cardiac dysrhythmias;
 - (2) Conduction disorders;
 - (3) Congestive heart failure;
 - (4) Myocardial infarction; and
 - (5) Pulmonary heart disease;
- (h) Hepatitis;
- (i) Human Immunodeficiency Virus;
- (j) Hyperlipidemia;
- (k) Hypertension;
- (l) Malignancies;
- (m) Mental health conditions including:
 - (1) Depression;
 - (2) Bipolar Disorder;

- (3) Manic Disorder;
- (4) Schizophrenia; and
- (5) Personality Disorders;

- (n) Paralysis;
- (o) Peripheral atherosclerosis;
- (p) Sickle cell anemia; and
- (q) Substance use disorder.

10201.2 The following categories of beneficiaries shall not be eligible for the *My Health GPS* program:

- (a) Beneficiaries enrolled in the Home and Community-Based Services (HCBS) Waiver for the Elderly and Individuals with Physical Disabilities, as described in Chapter 42 of Title 29 of the District of Columbia Municipal Regulations (DCMR);
- (b) Beneficiaries enrolled in the HCBS Waiver for Persons with Intellectual and Developmental Disabilities, as described in Chapter 19 of Title 29 DCMR;
- (c) Beneficiaries residing in a nursing facility;
- (d) Beneficiaries residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities; and
- (e) Beneficiaries enrolled in the *My DC Health Home* program, as described in Chapter 25 of Title 22-A DCMR.

10201.3 A beneficiary who is eligible for both the *My DC Health Home* and the *My Health GPS* programs may choose to enroll in either the *My DC Health Home* or the *My Health GPS* program but may not be concurrently enrolled in both programs.

10201.4 A beneficiary may be concurrently enrolled in a D.C. Medicaid risk-based managed care organization and the *My Health GPS* program.

- 10202.1 All beneficiaries who meet the eligibility criteria set forth in § 10201 may participate in the *My Health GPS* program.
- 10202.2 A beneficiary shall only be assigned to a single *My Health GPS* entity at any time in accordance with the process set forth below:
- (a) An eligible beneficiary shall be assigned to the *My Health GPS* entity that currently provides the beneficiary's primary care services or to a *My Health GPS* entity that is part of a corporate entity that currently provides the beneficiary's primary care services;
 - (b) If the beneficiary has a relationship with more than one (1) *My Health GPS* entity, as determined by the Department of Health Care Finance (DHCF) through a review of Medicaid claims submitted during the past twelve (12) months, the beneficiary shall be assigned to the *My Health GPS* entity seen most frequently during the review period;
 - (c) If a beneficiary who meets the criteria described in (b) 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; and
 - (d) If the beneficiary does not have a prior relationship with any *My Health GPS* entity, as determined by DHCF through a review of Medicaid claims submitted during the past twelve (12) months, the beneficiary shall be assigned to a *My Health GPS* entity based on the entity's capacity to serve additional beneficiaries and the geographic proximity of the beneficiary to the entity.
- 10202.3 The initial assignment of eligible beneficiaries shall occur after the initial application period described in § 10204.4(a) and shall be effective on the program implementation date. Eligible beneficiaries who enter the program after the initial assignment period shall be assigned on a time-basis established in accordance with guidance published to the DHCF website or within thirty (30) days of receipt of a referral.
- 10202.4 After an assignment is made, DHCF shall provide the beneficiary with the following information in writing:
- (a) A clear statement that the beneficiary has been identified as eligible to participate in the *My Health GPS* program;
 - (b) A clear explanation of the benefits of the *My Health GPS* program and the services provided;
 - (c) Information regarding the *My Health GPS* entity to which the beneficiary

has been assigned;

- (d) A clear explanation of the beneficiary's right to select a different *My Health GPS* entity or to "opt out" of the *My Health GPS* program; and
- (e) Instructions on selecting a different *My Health GPS* entity and "opting out" of the *My Health GPS* program.

10202.5 DHCF shall inform any other provider furnishing primary care services to an eligible beneficiary of the assignment, in writing, of the following:

- (a) A statement that the beneficiary served by the provider has been determined eligible for the *My Health GPS* program and assigned to a *My Health GPS* entity;
- (b) A clear explanation of the benefits of the *My Health GPS* program and the services provided; and
- (c) Information regarding the *My Health GPS* entity to which each beneficiary has been assigned.

10202.6 A beneficiary who has been assigned to a *My Health GPS* entity shall have the right to select a different entity or to "opt out" of the *My Health GPS* program.

10202.7 A beneficiary may notify DHCF at any time that the beneficiary wishes to select a different *My Health GPS* entity or "opt out" of the program.

10202.8 A beneficiary who has been assigned to a *My Health GPS* entity and wishes to be assigned to a different entity shall notify DHCF. The assignment to the new entity shall occur as follows:

- (a) If the beneficiary notifies DHCF of the new selection prior to the twentieth (20th) day of the month, the beneficiary shall be re-assigned to the new entity effective the first (1st) day of the month following the month in which the beneficiary notified DHCF of the new selection;
- (b) If the beneficiary notifies DHCF on or after the twentieth (20th) day of the month, the beneficiary shall be re-assigned to the new entity effective the first (1st) day of the second (2nd) month following the month in which the beneficiary notified DHCF of the new selection; and
- (c) The beneficiary shall remain eligible to receive *My Health GPS* services from the beneficiary's current *My Health GPS* entity until the effective date of the beneficiary's assignment to the new entity.

Any beneficiary assigned to a *My Health GPS* entity for whom the entity has not submitted an initial claim for a person-centered care plan in accordance with § 10207.12 within

the first two (2) quarters following the effective date of the beneficiary assignment, as described in § 10202.3, may be re-assigned to another *My Health GPS* entity in accordance with the process described in § 10202.2.

10202.10 If DHCF re-assigns a beneficiary to a new *My Health GPS* entity, DHCF shall provide the beneficiary the following information in writing:

- (a) A statement that the beneficiary remains eligible to participate in the *My Health GPS* program but has been re-assigned to a new *My Health GPS* entity;
- (b) A clear explanation of the benefits of the *My Health GPS* program and the services provided;
- (c) The reason the beneficiary has been re-assigned to a new *My Health GPS* entity;
- (d) Information regarding the new *My Health GPS* entity to which the beneficiary has been assigned;
- (e) A clear explanation of the beneficiary's right to select a different *My Health GPS* entity or to "opt out" of the *My Health GPS* program; and
- (f) Instructions on selecting a different *My Health GPS* entity and "opting out" of the *My Health GPS* program.

10202.11 If DHCF re-assigns a beneficiary to a new *My Health GPS* entity, DHCF shall notify the entity to which the beneficiary was previously assigned of the re-assignment in writing, including the following information:

- (a) A clear statement explaining why the beneficiary has been re-assigned;
- (b) Specific reference to the applicable sections of the rules, statute or provider manual; and
- (c) The effective date of the re-assignment.

10202.12 The effective date of a beneficiary's enrollment in the *My Health GPS* program shall be the date on which the *My Health GPS* provider completes the components of the beneficiary's person-centered plan of care in accordance with § 10207.12.

BENEFICIARY DISENROLLMENT

10203.1 DHCF shall disenroll an enrolled beneficiary from the *My Health GPS* program if:

- (a) The beneficiary's *My Health GPS* entity has not submitted claims for reimbursement for *My Health GPS* services provided to the beneficiary for three (3) consecutive quarters and DHCF has determined through an internal review that the beneficiary is no longer actively participating in the

My Health GPS program; or

- (b) DHCF determines that an enrolled *My Health GPS* beneficiary no longer meets the eligibility requirements as set forth under § 10201.

10203.2 If DHCF takes action to disenroll an enrolled beneficiary from the *My Health GPS* program as set forth in § 10203.1, DHCF shall issue a written notice to the beneficiary at least thirty (30) calendar days prior to the effective date of the intended disenrollment, which shall contain the following information:

- (a) A clear statement of the intended action to disenroll the beneficiary from the *My Health GPS* program;
- (b) An explanation of the reason(s) for the intended action;
- (c) Citations to the laws or regulations supporting the intended action;
- (d) An explanation of the beneficiary's right to request that DHCF reconsider its decision to disenroll the beneficiary, including the timeframe and procedures for making a request for reconsideration;
- (e) An explanation of the beneficiary's right to request a Fair Hearing, including the timeframe and procedures for requesting a hearing; and
- (f) The circumstances under which the beneficiary's current *My Health GPS* services will be continued if a reconsideration or Fair Hearing is requested.

10203.3 A request for reconsideration of the decision to disenroll a beneficiary made pursuant to § 10203.2(d) must be submitted in writing, by mail, fax, or in person, to DHCF within thirty (30) calendar days of the date of the notice of disenrollment described in § 10203.2. The request for reconsideration shall include information and documentation as follows:

- (a) A written statement by the beneficiary, or the beneficiary's designated representative, describing the reason(s) why the decision to disenroll the beneficiary should not be upheld;
- (b) A written statement by a clinician familiar with the beneficiary's health care needs describing the reason(s) why the decision to disenroll the beneficiary should not be upheld; and
- (c) Any additional, relevant documentation in support of the request.

10203.4 For beneficiaries currently receiving *My Health GPS* services, a timely filed request for reconsideration will stay the termination of services until a reconsideration decision is issued.

10203.5 DHCF shall issue a reconsideration decision no more than thirty (30) calendar days from the date of receipt of the documentation required in § 102033.

- 10203.6 If DHCF decides to uphold the disenrollment determination, the reconsideration decision shall contain the following:
- (a) A description of all documents that were reviewed;
 - (b) The justification(s) for the intended action(s) and the effective date of the action(s);
 - (c) An explanation of the beneficiary's right to request a Fair Hearing, including the timeframes and procedures for requesting a hearing; and
 - (d) The circumstances under which *My Health GPS* services will be provided during the pendency of a Fair Hearing.
- 10203.7 A request to appeal the reconsideration decision issued pursuant to § 10203.5 must be submitted within ninety (90) calendar days of the date of issuance of the reconsideration decision by requesting a Fair Hearing with the Office of Administrative Hearings in writing, in person, or by telephone, in accordance with 1 DCMR § 2971.
- 10203.8 DHCF shall not disenroll the beneficiary from the *My Health GPS* program while a Fair Hearing is pending if a beneficiary files the Fair Hearing request prior to the effective date of the proposed action to disenroll the beneficiary.

10204 MY HEALTH GPS ENTITY APPLICATION PROCESS

- 10204.1 The following types of organizations may become *My Health GPS* entities:
- (a) Primary care clinical individual practices;
 - (b) Primary care clinical group practices; and
 - (c) Federally Qualified Health Centers.
- 10204.2 In order to be eligible to become a *My Health GPS* entity, organizations described in § 10204.1 shall:
- (a) Be enrolled as a D.C. Medicaid provider in accordance with the requirements set forth in Chapter 94 of Title 29 DCMR;
 - (b) Have no current or pending investigations, exclusions, suspensions or debarment from any federal, State or District healthcare program; and
 - (c) Have no outstanding overpayment from DHCF.
- 10204.3 In addition to the minimum requirements set forth in §§ 10204.1 and 10204.2, each applicant shall be required to:

- (a) Provide proof of National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Level Two recognition (or successor version of equivalent recognition) or proof that the organization has initiated the NCQA PCMH application process for the prospective *My Health GPS* entity and that the recognition has been achieved within twelve (12) months of the date of submission of the *My Health GPS* application;
- (b) Demonstrate use of certified electronic health record (EHR) technology to support the creation and execution of a person-centered plan of care for each beneficiary;
- (c) Provide 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;
- (d) Demonstrate the availability of an interdisciplinary team with sufficient capacity to serve eligible beneficiaries including, at a minimum, qualified practitioners to fill each of the roles described in §§ 10205.3 and 10205.4;
- (e) Demonstrate the ability to deliver all *My Health GPS* services in accordance with the requirements described in § 10206, either directly through the organization or through a subcontractor;
- (f) Establish and maintain data sharing agreements with other healthcare providers as necessary in order to comply with all applicable requirements of the Health Insurance Portability and Accountability Act of 1996, effective August 21, 1996 (Pub. L. 104-191, 110 Stat. 1936); and
- (g) Provide proof of enrollment in the Chesapeake Regional Information System for Patients (CRISP) or comparable system, to receive hospital and emergency department alerts for enrolled beneficiaries.

10204.4 DHCF shall review applications from organizations described in § 10204.1 to become *My Health GPS* entities at the following times:

- (a) Applications shall initially be accepted for a thirty (30) day period which occurs prior to the program implementation date and which shall be communicated to all prospective *My Health GPS* entities on the DHCF website at: <http://dhcf.dc.gov>; and
- (b) Following the initial thirty (30) day application period, applications shall be reviewed on an ongoing basis.

10204.5 A prospective *My Health GPS* entity shall not be eligible for the initial assignment of eligible beneficiaries as described in § 10202.3, if the application is not received within the thirty (30) day period described in § 10204.4(a) and approved by DHCF.

- 10204.6 Approval of a prospective *My Health GPS* entity's application shall be contingent upon the entity's successful completion of a readiness review.
- 10204.7 DHCF shall return each application that is incomplete and afford the applicant two (2) opportunities to re-submit the application.
- 10204.8 If the applicant does not meet all of the requirements set forth in this chapter, DHCF shall deny enrollment in the *My Health GPS* program and issue a notice consistent with the requirements set forth in Chapter 94 of Title 29 DCMR.

10205 MY HEALTH GPS PROVIDER REQUIREMENTS

- 10205.1 Each *My Health GPS* provider shall contain an approved interdisciplinary team of practitioners, as described within this Section, embedded within the primary care setting of an organization described in § 10204.1.
- 10205.2 Each *My Health GPS* provider shall be adequately staffed, consistent with the requirements set forth in this section, by healthcare professionals who meet all applicable licensure and certification requirements of the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.* (2012 Repl. & 2016 Supp.)) and attendant regulations contained in Title 17 DCMR.
- 10205.3 Each *My Health GPS* provider serving lower-acuity (Group One) beneficiaries, as determined using the criteria set forth in § 10207.4, shall be comprised, at a minimum, of the following practitioners, or comparable practitioners as approved by DHCF on a case-by-case basis as set forth below:
- (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, 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.
- 10205.4 In addition to the practitioners described in § 10205.3, each *My Health GPS* provider serving higher-acuity (Group Two) beneficiaries, as determined using the criteria set forth in § 10207.4, shall also include the following practitioners, or practitioners with comparable qualifications as approved by DHCF on a case-by-case basis:
- (a) 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; and

- (b) A licensed Clinical Pharmacist, who is a Doctor of Pharmacy with experience in direct patient care environments, including but not limited to experience providing services in medical centers and clinics.
- (a) For *My Health GPS* providers serving lower-acuity (Group One) beneficiaries, the following minimum staffing ratios are required:
 - (1) Health Home Director: One half (0.5) full-time employee per four hundred (400) beneficiaries;
 - (2) Nurse Care Manager: One (1) full-time employee per four hundred (400) beneficiaries; and
 - (3) Peer Navigator: One (1) full-time employee per four hundred (400) beneficiaries;
- (b) For *My Health GPS* providers serving higher-acuity (Group Two) beneficiaries, the following minimum staffing ratios are required:
 - (1) Health Home Director: The equivalent of one-half (0.5) of a full-time employee's hours worked per four hundred (400) beneficiaries;
 - (2) Nurse Care Manager: Two (2) full-time employees per four hundred (400) beneficiaries;
 - (3) Peer Navigator: The equivalent of three and one-half (3.5) of the hours a full-time employee works per four hundred (400) beneficiaries;
 - (4) Care Coordinator: Two (2) full-time employees per four hundred (400) beneficiaries; and
 - (5) Clinical Pharmacist: The equivalent of one-half (0.5) of the hours full-time employee works per four hundred (400) beneficiaries.

10205.6 Each *My Health GPS* entity shall demonstrate that all its *My Health GPS* providers comply with the minimum staffing ratios set forth in § 10205.5 no later than the end of the second quarter following the effective date of the entity's enrollment in the *My Health GPS* program. A *My Health GPS* entity shall continue to comply with all minimum staffing ratios for the duration of the entity's enrollment in the program.

10205.7 If a *My Health GPS* entity fails to comply with the requirements set forth in § 10205.6, the entity may only be allowed to retain the number of beneficiaries whose needs are met by the entity's current *My Health GPS* providers. Any remaining beneficiaries may be re-assigned to another *My Health GPS* entity.

10205.8 If all *My Health GPS* providers within a *My Health GPS* entity have maximized capacity to serve the entity's enrolled beneficiaries in accordance with the staffing

ratios outlined in § 10205.5 and the entity is contacted by a beneficiary who wishes to receive *My Health GPS* services from any of its *My Health GPS* providers, the entity shall notify DHCF within one (1) business day of receiving a beneficiary's request for services.

10205.9 If beneficiaries are re-assigned to another *My Health GPS* entity pursuant to § 10205.7, DHCF shall notify the entity to which the beneficiaries were previously assigned of the re-assignment in writing consistent with the requirements set forth in § 10202.11.

10205.10 If DHCF re-assigns a beneficiary to a new *My Health GPS* entity, DHCF shall inform the beneficiary of the re-assignment in accordance with § 10202.10.

10205.11 Each *My Health GPS* provider shall conduct outreach to each beneficiary in accordance with the following timeframes:

- (a) The provider shall conduct outreach by the end of the second quarter following the effective date of the entity's enrollment for all beneficiaries initially assigned to the entity as described in § 10202.3; and
- (b) The provider shall conduct outreach by the end of the second quarter following the effective date of the beneficiary's assignment for all beneficiaries subsequently assigned to the entity as described in § 10202.3.

10205.12 Each *My Health GPS* provider shall document the outreach activity performed pursuant to § 10205.11 by including the following information in each beneficiary's EHR:

- (a) The date and time the activity was performed;
- (b) The identity of the *My Health GPS* provider staff member who performed the activity;
- (c) A description of the setting in which the activity was performed; and
- (d) A description of the activity, including mode of communication.

10205.13 In order to maintain enrollment as a *My Health GPS* entity, each organization described in § 10204.1 shall:

- (a) Participate in activities supporting the successful implementation of the *My Health GPS* program, including, but not limited to:
 - (1) Trainings to foster professional competency and development of best practices related to person-centered planning, chronic disease self-management, and related topics;
 - (2) Continuous quality improvement tasks, monitoring and performance reporting;
 - (3) District-wide initiatives to support the exchange of health

information; and

(4) Evaluations required by the Centers for Medicare and Medicaid Services (CMS), DHCF or its agent;

(b) Maintain compliance with all requirements set forth in this chapter; and

(c) Maintain compliance with all terms and conditions set forth in the entity's DC Medicaid provider agreement including all modifications, as well as with all applicable federal and District laws.

10205.14 Each *My Health GPS* entity shall enter into a Memorandum of Agreement (MOA) with each D.C. Medicaid Managed Care Organization (MCO). The MOA shall set forth the division of responsibilities between the MCO and the *My Health GPS* entity.

10206 MY HEALTH GPS SERVICES

10206.1 Each *My Health GPS* provider shall provide the following services to eligible beneficiaries:

(a) Comprehensive Care Management, as described in § 10206.3;

(b) Care Coordination, as described in § 10206.4;

(c) Health Promotion, as described in § 10206.5;

(d) Comprehensive Transitional Care, as described in § 10206.6;

(e) Individual and Family Support Services, as described in § 10206.7; and

(f) Referral to community and social support services, as described in § 10206.8.

10206.2 All *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, of the *My Health GPS* provider and documented in the *My Health GPS* provider's certified EHR.

10206.3 Comprehensive Care Management shall consist of the creation, documentation, execution and maintenance of a person-centered plan of care. Activities included in the delivery of Comprehensive Care Management services include, but are not limited to, the following:

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

- (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 components:
 - (1) A list of the beneficiary's chronic conditions;
 - (2) Issues identified during the comprehensive biopsychosocial needs assessment described in (a);
 - (3) Identification of the beneficiary's strengths and needs;
 - (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) Updating the person-centered plan of care in the *My Health GPS* provider's certified EHR system as follows:
 - (1) Every twelve (12) months if the beneficiary has had no significant change in health condition;
 - (2) Each time the beneficiary has a significant change in health condition; and
 - (3) Within fifteen (15) days of discharge each time the beneficiary has an unplanned inpatient stay; 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.

10206.4 Care Coordination shall consist of implementation of the person-centered plan of care through appropriate linkages, referrals, and coordination with needed services and supports. Care Coordination services include, but are not limited to, the following:

- (a) Scheduling appointments and providing telephonic appointment reminders;
- (b) Assisting the beneficiary in 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 a pediatric practice to an adult practice.

10206.5

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. 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.

10206.6 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. Comprehensive Transitional Care services shall include the following:

- (a) Conducting in-person 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.

10206.7 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. 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
- (i) Developing family support materials and services, including creating family support groups where appropriate.

10206.8 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. 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;
- (k) Faith-based organizations; and
- (l) Child care.

10206.9 Each *My Health GPS* entity shall ensure that enrolled beneficiaries do not receive services that duplicate *My Health GPS* services, as described in this chapter, through any other Medicaid-funded program.

10207 REIMBURSEMENT

10207.1 DHCF shall reimburse *My Health GPS* entities for the provision of covered *My Health GPS* services described in § 10206 using a per member per month (PMPM) payment structure.

10207.2 Effective upon December 1, 2018, DHCF shall establish three (3) distinct PMPM rates. A *My Health GPS* entity shall be eligible to receive only one of the following rates, per month, for each beneficiary enrolled in the *My Health GPS* program:

- (a) The PMPM rate to support the initial development of the person-entered care plan and annual, comprehensive re-evaluations of the beneficiary's care needs for both higher acuity and lower acuity beneficiaries. This PMPM shall only be available in the month in which the care plan is initially developed or an annual, comprehensive, re-evaluation of the beneficiary's care needs is performed;
- (b) The PMPM rate for higher acuity (Group Two) beneficiaries; and

- (c) The PMPM rate for lower acuity (Group One) beneficiaries.
- 10207.3 The PMPM rate set forth in § 10207.2(a) shall be higher than the acuity based PMPM rates set forth in §§ 10207.2(b) and (c). The PMPM rate for Group Two beneficiaries established in § 10207.2(b) shall be higher than the PMPM rate for Group One beneficiaries established in § 10207.2(c), reflecting the greater anticipated needs of Group Two beneficiaries for *My Health GPS* services and the additional *My Health GPS* provider staff required to serve Group Two beneficiaries.
- 10207.4 Except as set forth in § 10207.6, DHCF shall use a nationally-recognized risk adjustment tool and other criteria to determine the acuity level of each beneficiary in accordance with guidance published on the DHCF website. Based upon the results of the analysis, DHCF shall place the beneficiary into the appropriate acuity group.
- 10207.5 DHCF shall publish guidance on the methodology used to determine the acuity level of beneficiary on the DHCF website at dhcf.dc.gov. DHCF shall publish any changes to the methodology on the DHCF website at least thirty (30) calendar days before the changes are scheduled to take effect.
- 10207.6 A *My Health GPS* entity may request re-determination of a beneficiary's assigned acuity level as follows:
- (a) If re-determination is requested, a *My Health GPS* entity shall submit clinical documentation of a significant change in the beneficiary's health status to DHCF in the manner specified in the *My Health GPS* manual; and
- (b) If the documentation submitted in accordance with the *My Health GPS* manual by the *My Health GPS* entity is complete, DHCF shall re-determine the beneficiary's acuity level in accordance with the procedure set forth in §§ 10207.4.
- 10207.7 DHCF shall provide the *My Health GPS* entity with written notification of the results of the re-determination described in § 10207.6, including a copy of the re-determination analysis.
- 10207.8 The base PMPM rates for the rates set forth in § 10207.2 shall be established based on the staffing model described in §§ 10205.3 through 10205.5, and adjusted to take into account regional salaries, including fringe benefits. The rates shall also take into account the average expected service intensity for beneficiaries and shall be determined in accordance with the requirements of 42 USC § 1396a(a)(30)(A).
- 10207.9 Two (2) payment enhancements shall be added to the each PMPM rate set forth in § 10207.2 to:
- (a) Reflect the *My Health GPS* provider's overhead or administrative costs; and

- (b) Support the *My Health GPS* provider in procuring, using, or modifying health information technology.

10207.10 DHCF shall review the PMPM rates set forth in § 10207.2 on an annual basis to ensure that the rates are consistent with requirements set forth in 42 USC § 1396a(a)(30)(A).

10207.11 The PMPM rates set forth in § 10207.2 shall be listed in the D.C. Medicaid fee schedule, available at: www.dc-medicaid.com.

10207.12 In order to receive the first PMPM payment for an eligible beneficiary, a *My Health GPS* provider shall:

- (a) Inform the beneficiary about available *My Health GPS* program services;
- (b) Obtain the beneficiary's informed consent to receive *My Health GPS* program services in writing; and
- (c) Complete the following components of the person-centered plan of care in accordance with the standards for Comprehensive Care Management set forth in § 10206.3:
 - (1) Conduct an in-person needs assessment in accordance with § 10206.3(a);
 - (2) Enter available clinical information and information gathered at the in-person needs assessment into the person-centered plan of care which shall include individualized goals pursuant to § 10206.3(b)(4); and
 - (3) Retain documentation demonstrating the delivery of each of the activities described in (1) and (2) above.

10207.13 In order to receive a subsequent PMPM payment for an eligible beneficiary, a *My Health GPS* provider shall complete the person-centered plan of care in accordance with the standards set forth in § 10206.3, provide a copy of the completed plan of care to the beneficiary, and deliver at least one (1) *My Health GPS* program service to the beneficiary within the calendar month as follows:

- (a) For Group One beneficiaries, the service(s) provided during the month may be delivered face to face or remotely; and
- (b) For Group Two beneficiaries, at least one (1) service provided during the month shall be delivered face to face.

10207.14 *My Health GPS* entities shall be eligible for the PMPM payment set forth in § 10207.2(a) for the development of an initial person-centered care plan for each eligible beneficiary in Group One and Group Two. In order for the entity to receive the initial PMPM payment, the *My Health GPS* provider(s) shall meet all requirements set forth in § 10207.12 for each qualifying beneficiary.

- 10207.15 *My Health GPS* entities shall be eligible for the PMPM payment set forth in § 10207.2(a) for annual, comprehensive re-evaluations of the beneficiary's care needs for each eligible beneficiary in Group One and Group Two. In order for the entity to receive the annual PMPM payment, the *My Health GPS* provider(s) shall meet all requirements set forth in § 10207.12(c) for each qualifying beneficiary.
- 10207.16 For the initial and annual PMPM payment set forth in § 10207.2(a), *My Health GPS* entities shall be eligible to receive a maximum of one (1) payment per twelve (12) month period per beneficiary. If a *My Health GPS* entity received an incentive payment set forth in § 10209.2 for a beneficiary, no *My Health GPS* entity shall be eligible to receive an initial or annual PMPM payment set forth in § 10207.2(a) for the same beneficiary, until the twelfth (12th) month following the original month of service.
- 10207.17 For the initial and annual PMPM payments set forth in § 10207.2(a), a maximum of one (1) initial and annual PMPM payment is claimable per twelve (12) month period per beneficiary, regardless of a beneficiary's election to receive services from a different *My Health GPS* entity or "opt-out" of the program.
- 10207.18 Each *My Health GPS* provider shall document each program service and activity provided in each beneficiary's EHR. Any Medicaid claim for program services shall be supported by written documentation in the EHR which clearly identifies the following:
- (a) The specific service(s) rendered and descriptions of each identified service sufficient to document that each service was provided in accordance with the requirements set forth in § 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.
- 10207.19 Each claim for a *My Health GPS* service shall meet the requirements of § 10206 and shall be documented in accordance with § 10207.18 in order to be reimbursed.

10208 QUALITY REPORTING REQUIREMENTS

- 10208.1 Each *My Health GPS* entity shall report to DHCF, quarterly, on the following two (2) measure sets:

- (a) CMS “Core Set of Health Care Quality Measures for Health Home Programs” which may be located at the CMS website at: <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/Health-Home-Information-Resource-Center/quality-reporting/index.html>, in accordance with 42 USC § 1396w-4(g); and
- (b) The performance measures set forth in the table below:

My Health GPS Pay-for-Performance Measures				
Measure Name	Measure Domain	National Quality Forum Number	Steward	Description
1.Total Resource Use	Efficiency	1598	Health Partners	A risk adjusted measure of the frequency and intensity of services utilized by <i>My Health GPS</i> beneficiaries. Resource use includes all resources associated with treating <i>My Health GPS</i> beneficiaries including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services.
2. Total Cost of Care	Efficiency	1604	Health Partners	A risk adjusted measure of <i>My Health GPS</i> entity’s cost effectiveness at managing <i>My Health GPS</i> beneficiaries. Total cost of care includes all costs associated with treating <i>My Health GPS</i> beneficiaries including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services.

3. Plan All-Cause Readmission	Utilization	1768	NCQA	<p>For <i>My Health GPS</i> patients eighteen (18) years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within thirty (30) calendar days and the predicted probability of an acute readmission. Data is reported in the following categories:</p> <ol style="list-style-type: none"> 1. Count of Index Hospital Stays (denominator) 2. Count of thirty (30)-Day Readmissions (numerator) 3. Average adjusted Probability of Readmission
4. Potentially Preventable Hospitalization	Utilization	N/A	Agency for Healthcare Research and Quality	Percentage of inpatient admissions among <i>My Health GPS</i> beneficiaries for specific ambulatory care conditions that may have been prevented through appropriate outpatient care.
5. Low-Acuity Non-Emergent Emergency Department Visits	Utilization	N/A	DHCF	Percentage of avoidable low-acuity non-emergent ED visits among <i>My Health GPS</i> beneficiaries.

10208.2 DHCF shall notify *My Health GPS* entities of any changes in the performance measures or measure specifications in § 10208.1(b) through transmittals issued to *My Health GPS* entities at least ninety (90) days before the reporting of the data required for the measure begins.

10208.3 The baseline measurement period to determine the initial attainment and individualized improvement thresholds for measures outlined in § 10208.1(b) shall begin January 1, 2018 and end on December 31, 2018.

10208.4 All subsequent attainment and individualized improvement thresholds shall be determined for measures outlined in § 10208.1(b) on an annual basis from January 1 through December 31, unless otherwise specified by DHCF.

10208.5 Each *My Health GPS* entity shall utilize certified EHR technology to collect and report all data required for the quality measures described in §§ 10208.1(a) and 10208.1(b).

10208.6 Each *My Health GPS* entity shall submit hybrid data as required by CMS and DHCF in accordance with protocols outlined in the *My Health GPS* provider manual

- 10208.7 Each *My Health GPS* entity shall report each sentinel event to DHCF within twenty-four (24) hours of occurrence in accordance with the procedure set forth in the *My Health GPS* provider manual.
- 10208.8 Each *My Health GPS* entity may also be required to submit an annual program evaluation report to DHCF, which may include, but is not limited to, the following components:
- (a) The *My Health GPS* entity's approach to delivering 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.

10209 INCENTIVE PAYMENTS

- 10209.1 DHCF shall administer two (2) incentive payment programs for *My Health GPS* entities, as follows:
- (a) A person-centered plan of care incentive payment program, as described in § 10209.2; and
 - (b) A pay-for-performance incentive program, as described in §§ 10209.3 through 10209.13.
- 10209.2 During the period beginning July 1, 2017 and ending October 31, 2017, all *My Health GPS* entities shall be eligible for a single incentive payment for each eligible beneficiary to support development of the person-centered plan of care. In order for the entity to receive the incentive payment, its *My Health GPS* provider(s) shall meet all requirements of § 10207.12 for each qualifying beneficiary within the period beginning July 1, 2017 and ending October 31, 2017.
- 10209.3 Each *My Health GPS* entity shall participate in the *My Health GPS* pay-for-performance incentive program for all four (4) quarters of each measurement year. If an entity is not enrolled in the *My Health GPS* program for all four (4) quarters of a measurement year, the following provisions regarding participation in the pay-for-performance incentive program apply:
- (a) If a *My Health GPS* entity enrolls in the *My Health GPS* program after the first day of the first quarter of the measurement year, the entity shall not be eligible for the performance payment described in § 10209.13 for that measurement year, but shall receive the full amount of the percentage withheld for that measurement year, as described in § 10209.6; and
 - (b) If a *My Health GPS* entity is enrolled in the *My Health GPS* program on the first (1st) day of the first quarter of the measurement year but is no longer enrolled in the program on the last day of the last quarter of the measurement

year, the entity shall not be eligible for either the performance payment described in § 10209.13 or any portion of the percentage withheld for that measurement year, as described in § 10209.6.

- 10209.4 A *My Health GPS* entity's performance in the pay-for-performance incentive program will be assessed against the entity's attainment or individualized improvement thresholds developed during the periods outlined in §§10208.3 and 10208.4.
- 10209.5 DHCF shall inform all *My Health GPS* entities of the attainment and individualized improvement thresholds for each of the measures outlined in §10208.1(b) prior to the start of each measurement year of the pay-for - performance incentive program.
- 10209.6 The first (1st) measurement year for the pay-for-performance incentive program shall begin on October 1, 2019. *My Health GPS* entities shall be subject to a percentage withheld from every PMPM payment for services rendered during the measurement year, as follows:
- (a) Measurement Year One (Fiscal Year 2020): Ten percent (10%);
 - (b) Measurement Year Two (Fiscal Year 2021): Fifteen percent (15%); and
 - (c) Measurement Year Three (Fiscal Year 2022) and all subsequent performance periods: Twenty percent (20%).
- 10209.7 *My Health GPS* entities shall be assessed based on either attainment or improvement on the measures described in § 10208.1(b) on an annual basis for the pay-for-performance incentive program. If a *My Health GPS* entity did not meet or exceed its attainment threshold, then DHCF shall assess whether the *My Health GPS* entity met or exceeded its individualized improvement threshold. The following guidelines are set forth below:
- (a) A *My Health GPS* entity must meet or exceed the seventy-fifth (75th) percentile based on the attainment threshold; or
 - (b) A *My Health GPS* entity must demonstrate a statistically significant improvement based on the individualized improvement threshold. A statistically significant improvement has a probability of 0.05 that the improvement was not due to random error. DHCF shall perform the appropriate statistical analysis (*e.g.*, t-test) to determine that the performance between measurement years is a result that cannot be attributed to chance.
- 10209.8 DHCF shall provide written notification of the attainment and individualized improvement thresholds to each *My Health GPS* entity after all measures are received and validated for the pay-for-performance incentive program.
- 10209.9 A *My Health GPS* entity may opt to aggregate its beneficiary population with another *My Health GPS* entity's population for the purposes of calculating

attainment or improvement on any of the required measures described in § 10208.1(b) in the pay-for-performance incentive program subject to the following conditions:

- (a) Each *My Health GPS* entity shall notify DHCF of its selection of the aggregation option no later than September 1st prior to the measurement year;
- (b) *My Health GPS* entities opting to aggregate their populations together shall do so for calculation of all measures during a given baseline or measurement year;
- (c) *My Health GPS* entities opting to aggregate their populations together must do so for calculation of all measures during a given baseline or measurement year;
- (d) Each *My Health GPS* entity shall report data that is identifiable for the *My Health GPS* entity's individual performance, along with the aggregated data;
- (e) A *My Health GPS* entity shall elect the option to aggregate annually and may change its selection, including opting against pooling or opting to pool with a different *My Health GPS* entity, on an annual basis; and
- (f) When a *My Health GPS* entity has opted to aggregate beneficiaries, performance is measured for the aggregated *My Health GPS* entity throughout the duration of the measurement year unless one (1) of the aggregated entities withdraws from the *My Health GPS* program during the measurement year. If one (1) of the *My Health GPS* entities that has opted to aggregate beneficiaries withdraws before the measurement year is complete, the remaining *My Health GPS* entity's performance will be measured based on the remaining *My Health GPS* beneficiaries.

10209.10 For each measurement year, the maximum amount of funding available to qualifying *My Health GPS* entities for the pay-for-performance incentive program shall be equal to one and one-half (1.5) times the measurement year withhold amount percentage, as outlined in § 10209.6.

10209.11 To determine the *My Health GPS* entity's annual performance in the pay-for-performance incentive program, DHCF shall score each participating *My Health GPS* entity's performance in three (3) measurement domains. This scoring will be determined as follows:

- (a) A maximum of one hundred (100) points will be awarded to each *My Health GPS* entity's across the efficiency, utilization, and process domains described in § 10208.1(b);
- (b) Each measure in the domain is assigned points by dividing the total points by the number of measures in each domain. Points for each domain are

described in the table set forth in (c);

(c)

<i>My Health GPS</i> Entity Performance Measure Point Distribution Methodology	Measurement Year1 (FY 2020)	Measurement Year 2 (FY 2021)	Measurement Year 3 and on (FY 2022)
Total Efficiency Domain Points <i>(allowed points per measure)</i>	50 <i>(25)</i>	50 <i>(25)</i>	50 <i>(25)</i>
Total Utilization Domain Points <i>(allowed points per measure)</i>	50 <i>(16.66)</i>	50 <i>(16.66)</i>	50 <i>(16.66)</i>
Total Performance Points	100	100	100

(d) Points for each measure shall be awarded in cases where a *My Health GPS* entity meets either the attainment or improvement threshold based on the prior measurement year’s performance as described below:

- (1) A *My Health GPS* entity shall receive points if it met or exceeded the seventy-fifth (75th) percentile attainment benchmark;
- (2) A *My Health GPS* entity performing below the attainment benchmark may be able to receive the allowed points per measure as described in (c) for each measure if it has met or exceeded its improvement threshold described in § 10209.7(b); and
- (3) If a *My Health GPS* entity neither attains nor improves performance on a given measure, zero (0) points will be awarded for that measure;

(e) The amount of the incentive payment that a *My Health GPS* entity shall be eligible to receive shall be calculated as follows:

- (1) Sum points awarded for each measure in the domain to determine the domain totals;
- (2) Sum domain totals to determine total performance points;
- (3) Divide total performance points by the maximum allowed points to determine the performance period percentage; and
- (4) The amount in (3) shall be multiplied by one and one-half (1.5) times the performance period withhold amount for the *My Health GPS* entity, calculated in accordance with the withhold amount percentage for the measurement year, as set forth in § 10209.6.

10209.12 If *My Health GPS* entities have aggregated beneficiaries together for determination

of performance in the pay-for-performance incentive program, the award percentage for the aggregated entities shall be applied to each *My Health GPS* entity's maximum incentive payment amount to determine the *My Health GPS* entities performance award individually.

10209.13 Beginning with FY 2020, and annually thereafter, performance payments for the pay-for-performance incentive program shall be calculated and distributed after the conclusion of each measurement year once all measures are calculated and have been validated for each *My Health GPS* entity.

10210 AUDITS AND REVIEWS

10210.1 DHCF shall perform audits of *My Health GPS* entities to ensure that Medicaid payments for *My Health GPS* services are consistent with efficiency, economy and quality of care, and made in accordance with federal and District conditions of payment.

10210.2 DHCF audits of *My Health GPS* entities shall be conducted when necessary to investigate and maintain program integrity.

10210.3 DHCF shall perform audits of claims submitted by *My Health GPS* entities, including using statistically valid scientific sampling, to determine the appropriateness of *My Health GPS* services rendered and billed to Medicaid to ensure that Medicaid payments can be substantiated by documentation that meets the requirements set forth in § 10207.18 and are made in accordance with all requirements of this chapter and all other applicable federal and District laws.

10210.4 If DHCF determines that any claim(s) submitted by a *My Health GPS* entity were not submitted in accordance with all requirements of this Chapter and all other applicable federal and District laws, DHCF shall deny the identified claim(s) and recoup those monies erroneously paid to a *My Health GPS* entity following the period of Administrative Review, as set forth in § 10210.6.

10210.5 If DHCF recoups monies erroneously paid to a *My Health GPS* entity for denied claims, DHCF shall issue a Proposed Notice of Medicaid Overpayment Recovery (PNR) to the *My Health GPS* entity, which sets forth the reasons for the recoupment, the amount to be recouped, and the procedures and timeframes for requesting an Administrative Review of the PNR.

10210.6 The *My Health GPS* entity shall have thirty (30) calendar days from the date of the PNR to request an Administrative Review, which may be extended for good cause. The *My Health GPS* entity may submit documentary evidence and written argument against the proposed action to DHCF in the request for an Administrative Review. If the *My Health GPS* entity fails to respond to the PNR within thirty (30) calendar days or by the extended deadline if good cause has been granted, DHCF shall issue a Final Notice of Medicaid Overpayment Recovery (FNR), which shall include the procedures and timeframes for requesting an appeal.

10210.7 DHCF shall review the documentary evidence and written argument submitted by the *My Health GPS* entity against the proposed action described in the PNR. After

this review, DHCF may cancel its proposed action, amend the reasons for the proposed recoupment and adjust the amount to be recouped. DHCF shall then issue a FNR, which shall include the procedures and timeframes for requesting an appeal.

10210.8 The *My Health GPS* entity may appeal the FNR by filing a written hearing request with the Office of Administrative Hearings within fifteen (15) calendar days from the date of the FNR. The written notice requesting an appeal shall include a copy of the FNR, description of the item to be reviewed, the reason for review of the item, the relief requested, and any documentation in support of the relief requested.

10210.9 Filing an appeal shall not stay any action to recover any overpayment.

10210.10 In lieu of the off-set of future Medicaid payments, the *My Health GPS* entity may choose to send a certified check made payable to the District of Columbia Treasurer in the amount of the funds to be recouped within thirty (30) calendar days following the period of Administrative Review as set forth in § 10210.6.

10210.11 Each *My Health GPS* entity shall allow access to all relevant records and program documentation during an on-site audit or review to DHCF, its designee, other authorized District of Columbia government officials, the Centers for Medicare and Medicaid Services (CMS), and representatives of the United States Department of Health and Human Services.

10210.12 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.

10211 MY HEALTH GPS SANCTIONS, WITHDRAWAL AND TERMINATION

10211.1 DHCF may determine at any time during a *My Health GPS* entity's enrollment in the program that the entity has failed to meet one (1) or more requirements of program participation, and may request the submission of a Corrective Action Plan (CAP) to remedy the identified issue(s). All *My Health GPS* entities shall be required to submit a proposed Corrective Action Plan (CAP) under circumstances including, but not limited to, the following:

- (a) Failure to meet any requirements set forth in this chapter;
- (b) Failure to comply with all terms of the D.C. Medicaid Provider Agreement; or
- (c) Failure to meet any quality standards using the measures described in § 10208.1.

10211.2 If DHCF identifies a *My Health GPS* entity's non-compliance in any of the areas described in § 10211.1, DHCF shall notify the entity of the identified issue(s) and a timeframe for submission of a proposed CAP to remedy the issue(s).

10211.3 If a *My Health GPS* entity is notified of a non-compliance issue as set forth in §

10211.2 and fails to submit a proposed CAP within the timeframe identified in the notification, DHCF shall notify the entity of the failure to submit the proposed CAP and may impose the following sanctions:

- (a) Deny further assignments of beneficiaries;
- (b) Deny incentive payments as described in §10209.1;
- (c) Seek repayment from the *My Health GPS* entity for services rendered during the time period of non-compliance; or
- (d) Terminate the entity's participation in the *My Health GPS* program.

10211.4 A proposed CAP shall include, at minimum, the following components:

- (a) A comprehensive statement of the non-compliance issue identified in the notice issued pursuant to § 10211.2;
- (b) The entity's proposed course of action for resolving the identified non-compliance issue;
- (c) Identification of the staff members responsible for resolving the issue;
- (d) Timeframes for execution of the proposed course of action; and
- (e) Designation of reporting periods for providing updates to DHCF.

10211.5 DHCF shall review each proposed CAP to determine whether it meets all requirements set forth in § 10211.4.

10211.6 If an entity's proposed CAP fails to meet any of the requirements set forth in § 10211.4, DHCF shall notify the entity of the identified deficiencies in the proposed CAP and provide a timeframe in which the CAP must be re-submitted.

10211.7 Once the proposed CAP meets all requirements set forth in § 10211.4, DHCF shall approve the CAP and monitor the entity's progress towards timely correction of all deficiencies. If the *My Health GPS* entity fails to resolve the deficiencies, DHCF may impose the sanctions described in § 10211.3.

10211.8 If DHCF determines that any of the actions set forth in §§ 10211.3 or 10211.7 are necessary, DHCF shall issue a notice to the entity containing the following information:

- (a) A clear statement of the intended action;
- (b) The effective date of the intended action;
- (c) An explanation of the reason(s) for the intended action;
- (d) Specific reference to the particular sections of the statutes, regulations or

provider manual supporting the intended action; and

- (e) Information regarding the entity's right to dispute the allegations and to submit evidence to support his or her position.

10211.9 The *My Health GPS* entity may submit documentary evidence to refute DHCF's argument for imposition of an alternative sanction within thirty (30) days of the date of the notice described in § 10211.8.

10211.10 DHCF may extend the thirty (30) day period prescribed in § 10211.10 for good cause on a case-by-case basis.

10211.11 If DHCF determines that any of the actions set forth in §§ 10211.3 or 10211.7 is necessary after the *My Health GPS* entity has issued a response under § 10211.9, DHCF shall issue a final notice to the entity at least fifteen (15) days before the imposition of the alternative sanction, including the following information:

- (a) The reason for the decision;
- (b) The effective date of the sanction;
- (c) Information regarding the right to appeal the decision by filing a hearing request with the Office of Administrative Hearings and the timeframe and procedures for filing a hearing request; and
- (d) If applicable, information regarding the transfer of beneficiaries to another *My Health GPS* entity and the timeframe for completing the transfer.

10211.12 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 described in § 10211.11, then the effective date of the proposed action shall be stayed until the Office of Administrative Hearings has rendered a final decision.

10211.13 If a *My Health GPS* entity wishes to withdraw from the program or to remove a provider from the *My Health GPS* portion of its D.C. Medicaid Provider Agreement, the entity shall take the following action:

- (a) If the entity wishes to withdraw from the program, the entity shall give ninety (90) days written notice of the intended withdrawal to DHCF, which includes a comprehensive plan to transfer all of the entity's affected beneficiaries to another *My Health GPS* provider or entity; and
- (b) If the entity wishes to remove a provider from the *My Health GPS* portion of its D.C. Medicaid Provider Agreement, the entity shall give ninety (90) days written notice of the intended removal to DHCF, which includes a comprehensive plan to transfer all of the entity's affected beneficiaries to another *My Health GPS* provider or entity and execute a modified *My Health GPS* Agreement.

10299 **DEFINITIONS**

10299.1

Beneficiary - An individual deemed eligible for and in receipt of services provided through the District Medicaid program.

Corporate Entity – An organization that holds a single Employer Identification Number, as defined in 26 CFR § 301.7701-12.

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(1)(2)(B) of the Social Security Act (42 USC § 1396d(1)(2)(B)).

District Fiscal Year - A twelve (12) month period beginning on October 1st and ending on September 30th.

Hybrid Data – A combination of administrative data (i.e. claims, encounters, and vital records) and clinical data contained in medical records.

My Health GPS 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 *My Health GPS* provider into its primary care service delivery structure.

My Health GPS Provider – An approved interdisciplinary team that delivers *My Health GPS* services within a *My Health GPS* entity.

Opt Out – The process by which a beneficiary chooses not to participate in the *My Health GPS* 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.

Performance Period – A full District fiscal year, beginning in Fiscal Year 2019.

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.