GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

My Health GPS Provider Manual

Health Care Delivery and Management Administration

July 1, 2017

Table of Contents

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. The *My Health GPS* program is an initiative to address the unmet care management needs of beneficiaries who have had preventable utilization of emergency medical services, avoidable emergency department services and hospital admissions, and poor health outcomes. *My Health GPS* services will be delivered by an interdisciplinary team in the primary care setting, which will coordinate patient-centered and population-focused care for these beneficiaries. The *My Health GPS* program will be the District's second Health Home program.

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 supports for persons with chronic conditions.

III. Program Overview

Starting July 1, 2017, DHCF will provide a per member per month payment to approved primary care providers who deliver comprehensive care management services to District Medicaid beneficiaries with three or more qualifying chronic conditions. The care management services will be delivered by an interdisciplinary team embedded in the primary care setting and aims to improve the integration of medical and behavioral health, and community supports and social services.

The My Health GPS program is designed to result in 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 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 (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. Beneficiary Eligibility

Beneficiaries eligible to participate in the My Health GPS program must be a DC Medicaid beneficiary. 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

A beneficiary may be concurrently enrolled in a DC Medicaid risk-based managed care organization and the *My Health GPS* program. However, DC Medicaid beneficiaries who are already receiving comparable services are not eligible for the *My Health GPS* program. For example, beneficiaries enrolled in the in the following programs:

1. Home and Community-Based Services (HCBS) Waiver for the Elderly and Individuals with Physical Disabilities;
2. HCBS Waiver for Persons with Intellectual and Developmental Disabilities;

or being served in the following settings:

3. Nursing facility; and
4. Intermediate Care Facility for Individuals with Intellectual Disabilities.

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.

V. Beneficiary Attribution and Assignment

Beneficiary attribution and assignment is conducted on a quarterly basis utilizing 12 months of prior Medicaid claims. Prior to the initiation of the program there will be an initial assignment of eligible

beneficiaries immediately following the initial provider application period. These beneficiaries will be eligible for the *My Health GPS* program effective, July 1, 2017.

Assignment Procedures

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.

In the event that a beneficiary does not have one (1) current provider, assignment will be made in accordance with the following process:

- If the beneficiary has a relationship with more than one (1) *My Health GPS* entity, based on a DHCF review of twelve (12) months of Medicaid claims, the beneficiary shall be assigned to the *My Health GPS* entity seen most frequently during the review period.
- 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.
- If the beneficiary does not have a prior relationship with any *My Health GPS* entity, as determined based on 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.

DHCF is required to accept referrals to *My Health GPS* from health care providers. These procedures are outlined below:

A *My Health GPS* entity may refer a beneficiary to the *My Health GPS* program by submitting a written request along with supporting documentation. The supporting documentation must include:

a) the name and Medicaid ID number of the beneficiary;
b) the name of the My Health GPS entity; and
c) evidence that a provider has submitted claims for the beneficiary identifying three or more qualifying chronic conditions.

This documentation must be sent securely to myhgps@dc.gov. 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. If a beneficiary is referred by another health care provider, the attribution and assignment process will be used to determine which *My Health GPS* entity will be assigned.

DHCF will notify all beneficiaries in writing, 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.

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. Using this tool, DHCF will assign a risk score to each beneficiary. Beneficiaries without a score or a score under 5.0 will be placed in the lower acuity group (Group One). Beneficiaries with a score of 5.0 or higher will be placed in the higher acuity group (Group Two).

A My Health GPS entity may request re-determination of a beneficiary's assigned acuity level at any time. If re-determination is requested, a My Health GPS entity will be required to submit clinical documentation to DHCF to demonstrate a significant change in the beneficiary's health status. The documentation must include:

a) the name and Medicaid ID number of the beneficiary;
b) the name of the My Health GPS entity;
c) evidence that a provider within the My Health GPS entity has submitted new claims for the beneficiary; and
d) a summary of the clinical changes that compel an acuity re-determination.

This documentation must be sent securely to myhgps@dc.gov. Upon receipt of the clinical documentation, DHCF will re-determine the beneficiary's acuity level. DHCF will provide the *My Health GPS* entity with written notification of the results of the re-determination. Absent a redetermination that changes a beneficiary's acuity level, the beneficiary's acuity level is fixed for the first year of the program.

Re-assignment

The *My Health GPS* provider shall document all attempts to outreach to the beneficiary. If the provider has made reasonable attempts to engage the beneficiary in care, and the beneficiary has not consented and enrolled into the *My Health GPS* program after 9 months, the provider will notify DHCF, who will send a written notice to the beneficiary. At the Department's discretion, DHCF may reassign the beneficiary (based on the process outlined above, excluding the current *My Health GPS* entity) to another *My Health GPS* entity or exclude the beneficiary from the My Health GPS program.

Opt Out

A beneficiary assigned to the My Health GPS program may elect not to participate. Should a beneficiary choose not to participate s/he may opt out of the *My Health GPS* program. Beneficiaries that elect not to participate will remain eligible for Medicaid coverage. The beneficiary may complete the Opt Out Form (See Appendix A). Additionally the beneficiary can contact DHCF or their *My Health GPS* provider to which s/he has been assigned to opt out over the phone. The *My Health GPS* provider will complete an Opt Out form on behalf of the beneficiary and submit to myhgps@dc.gov.

Upon notification that a beneficiary has opted-out, DHCF will notify the assigned provider and remove him/ her from the list of eligible participants. DHCF will also notify the beneficiary in writing that s/he

has chosen not to participate and that s/he may decide to participate in the My Health GPS program at any time.

Change of *My Health GPS* Entities

A beneficiary may select another *My Health GPS* entity according to individual need and preference. Likewise, *My Health GPS* entities may determine a beneficiary may be better served by another My Health GPS provider due to capacity limits, limitations in integrating care, or other barriers to integrated care. 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* entity can be accomplished by submitting a Provider Change form (See Appendix A) to myhgps@dc.gov. The request can be made by the beneficiary, *My Health GPS* entity, or Managed Care Organization (MCO). For requests received on or before the 20th of the current month, the new enrollment shall begin the first day of the following month. If a request is received on or after the 21st of the current month, the enrollment shall begin the first day of the month after the following month.

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

VI. Beneficiary Enrollment

A beneficiary assigned to a provider is not automatically enrolled into the My Health GPS program. Enrollment begins after the beneficiary has consented (written) to participate in the program *and* the *My Health GPS* entity submits its first comprehensive care management claim. The required documentation for this claim includes:

a) A signed the My Health GPS consent form (Appendix A);
b) A completed a biopsychosocial (BPS) needs assessment; and
c) An interim care plan.

Interim Care Plan

(1) Conduct an in-person needs assessment;
(2) Enter available clinical information and information gathered at the in-person 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.

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

- The beneficiary withdraws consent to participate in *My Health GPS (see Appendix A)*;
- The beneficiary is no longer eligible for DC Medicaid;

- The beneficiary is no longer meets the criteria for eligibility in *My Health GPS*; or
- 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).

Consent to Participate and Notice of Privacy Practices (NPP)

When a beneficiary elects to participate in the *My Health GPS* program s/he must sign the *My Health GPS* Consent Form (see Appendix A). A copy of the beneficiary's signed consent form must be provided to the beneficiary.

In addition, because all My Health GPS providers are required to participate in Health Information Exchange (HIE), providers' notice of privacy practices must align. To ensure that beneficiaries are fully informed about the appropriate uses of their protected health information (PHI) and the ways in which the privacy and security of their PHI is protected, all *My Health GPS* providers are required, at a minimum, to include the following concepts in their NPPs:

NPP Description of HIE Services must include:

- ✓ *which HIE provides these services;*
- ✓ *the types of providers with whom health information is exchanged;*
- ✓ *a link to information on HIE services or further information on HIE.*

- Provide a description of HIE services;
- Explain individual's right to opt out of HIE, and provide information on steps to opt out of HIE;
- 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).

VII. Delivery of Services

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

The *My Health GPS* services are:

1. **Comprehensive Care Management** consists 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 BPS 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. The components of the BSP 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 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

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 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;

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.

2. 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; and

n) Ensuring that the beneficiary is connected to and maintains eligibility for any public benefits to which the beneficiary may be entitled, including Medicaid.

3. 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.

4. 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, but are not limited to, 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.

5. 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.

6. 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;
   j) Faith-based organizations; and
   k) Child care.

VIII. Provider Enrollment

In order to be eligible to become a *My Health GPS* entity, organizations must meet or exceed the following requirements:

- Be enrolled as a DC Medicaid provider in accordance with the requirements set forth in Chapter 102 of Title 29 of the DCMR;
- Not have current or pending investigations, exclusions, suspensions or debarment from any federal, State or District healthcare program; and
- Not have any outstanding overpayment from DHCF.

Only organizations that are a primary care clinical individual, group practice, or Federally Qualified Health Centers are eligible to apply to become a My Health GPS entity. In addition to the minimum requirements, each applicant shall be required to provide proof of National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Level Two recognition. However, if the applicant does not already possess the credential, the organization must submit evidence that they have initiated the NCQA PCMH application process. The applicant must receive the NCQA PCMH credential within twelve (12) months of the date of submission of the *My Health GPS* application.

Provider Requirements

All *My Health GPS* entities are required to demonstrate the following:

a) Certified electronic health record (EHR) with the ability to document a person-centered care plan;
b) 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;
c) Availability of an interdisciplinary team;
d) Enrollment in the Chesapeake Regional Information System for Patients (CRISP) to receive hospital and emergency department alerts for enrolled beneficiaries.

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.

Managed Care Organizations

The *My Health GPS* program is available for beneficiaries that are on DC Fee for Service (FFS) Medicaid or DC Managed Care Organization (MCO) Medicaid. A beneficiary may be concurrently enrolled in a DC Medicaid risk based Managed Care Organization and the My Health GPS program. In order to effectively coordinate care for beneficiaries enrolled in a MCO, each entity must enter into a Memorandum of Agreement (MOA) with each MCO. Each My Health GPS entity and MCO must have a beneficiary liaison to avoid unintended duplication of services.

The *My Health GPS* provider shall develop the care plan and provide care coordination services in partnership with the MCO. Ultimately, the MCO is responsible for the care management of the beneficiary, therefore, the MCO and the *My Health GPS* provider will clearly outline the monitoring plan and service provisions in the MOA as prescribed in the Patient Centered Medical Home (PCMH) certification standards.

IX. Staffing

Each *My Health GPS* provider serving lower-acuity (Group One) beneficiaries 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, 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.

In addition to the practitioners described above, each *My Health GPS* provider serving higher-acuity (Group Two) beneficiaries 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.

The minimum staffing ratios for providers are as follows:

(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.

X. Quality Reporting Requirements

Quality measurement of the processes and outcomes of the *My Health GPS* program will be necessary to understand the value of the overall program and the efficacy of any one component. Measurements also will guide any improvement process. The primary method of assessing the *My Health GPS* program will be through the CMS Health Home Core Quality Measures. These quality measures will be used to evaluate care, providing benchmarks and indicators for program evaluation. The CMS guidance and final Health Home core measures can be found at the following link:

https://www.medicaid.gov/license-agreement.html?file=%2Fstate-resource-center%2Fmedicaid-state-technical-assistance%2Fhealth-homes-technical-assistance%2Fdownloads%2FFFY-16-HH-Core-Set-Manual.pdf

Hybrid Measure Reporting

DHCF will provide a reporting template for My Health GPS providers to utilize for submission through an SFTP portal.

My Health GPS Performance Measures

Measure Name	Description
Plan- All Cause Re-admission	Count the number of Index Hospital Stays, discharge, then a readmission within 30 days for each age, gender, and total combination
Chronic Care Composite: Ambulatory Care-Sensitive Condition Admission	Total number of acute care hospitalizations for the following ambulatory care sensitive conditions: o Diabetes- short term complications, long term complications, uncontrolled, lower extremity amputations

Measure Name	Description
	o COPD/Asthma o Hypertension o Heart Failure o Angina without procedure
Follow-up after hospitalization for mental illness	Beneficiaries 6 years of age and older with a principal mental health diagnosis who are discharged from an acute inpatient setting will have an outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days after discharge.
Adult body mass index (BMI) assessment	Beneficiaries 18-74 years of age who had an outpatient visit and body mass index documented during the measurement year or the year prior to the measurement year.
Screening for clinical depression and follow-up plan	All patients 18 years and older screened for clinical depression using a standardized tool, the PHQ-9 for example, and who had a follow-up visit when indicated by a positive result.
Controlling high blood pressure	Patients 18-85 years of age with hypertension whose BP is less than 140/90 and are controlled.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of adolescents (13+) and adults members with a new episode of alcohol or other drug dependence who received treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis.
Ambulatory Care – Emergency Department Visits	Rate of emergency department (ED) visits per 1,000 enrollee months among *My Health GPS* enrollees.
Inpatient Utilization—General hospital/Acute Care	All acute hospitalizations maternity, mental health, surgery, medicine.
Care Transition- Transition Record Transmitted to Health Care Professional	Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.
Follow-up after Hospitalization for Mental Illness	Beneficiaries 6 years of age and older with a principal mental health diagnosis who are discharged from an acute inpatient

Measure Name	Description
	setting will have an outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days after discharge.
Nursing Facility Utilization	The 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 per 1,000 enrollee months.

Pay for Performance

DHCF has seven (7) measures that will be used to evaluate the performance of *My Health GPS* entities. These measures cover three domains – Efficiency, Utilization and Process – that will help improve the quality and overall value of health care. A full description of the process is outlined in 29 DCMR § 10209.

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 *My Health GPS* beneficiaries. Resource use includes all resources associated with treating *My Health GPS* 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 *My Health GPS* entity's cost effectiveness at managing *My Health GPS* beneficiaries. Total cost of care includes all costs associated with treating *My Health GPS* beneficiaries including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services.

My Health GPS Pay-for-Performance Measures				
Measure Name	**Measure Domain**	**National Quality Forum Number**	**Steward**	**Description**
3. Plan All-Cause Readmission	Utilization	1768	NCQA	For My Health GPS patients 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: 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 My Health GPS 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 My Health GPS beneficiaries.
6. Reconciled Medication List	Process	0646	American Medical Association-Physician Consortium for Performance Improvement	Percentage of My Health GPS beneficiaries, regardless of age, discharged from an inpatient facility (e.g, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge.
7. Timely Transmission of Transition Record	Process	0648	American Medical Association-Physician Consortium for Performance Improvement	The percentage of My Health GPS beneficiaries, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to their home or any other site of care for whom a transition record was transmitted to the My Health GPS entity within twenty-four (24) hours of discharge.

XI. Sentinel Event Reporting

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. Further guidance will be forthcoming.

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 and 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 § 10207.12 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 fully 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 in which the entity must submit 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 that are out of compliance are subject, but not limited, to the following sanctions:

- Deny further assignments of beneficiaries;
- Deny incentive payments;
- Seek repayment from the *My Health GPS* entity for services rendered during the time period of non-compliance; or
- Terminate 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 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.

An entity may decide to withdraw their participation from the *My Health GPS* program or remove a 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 give ninety (90) days written notice of the intended withdrawal to DHCF. The written notice must include a comprehensive plan to transfer all of the entity's affected beneficiaries to another *My Health GPS* provider or entity. The entity shall also execute a modified *My Health GPS* Agreement.

XIV. Billing and Reimbursement

My Health GPS (Health Home II) Billing Guide

Date: 06/29/2017
Version: 1.01

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 Conduent 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 Conduent 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

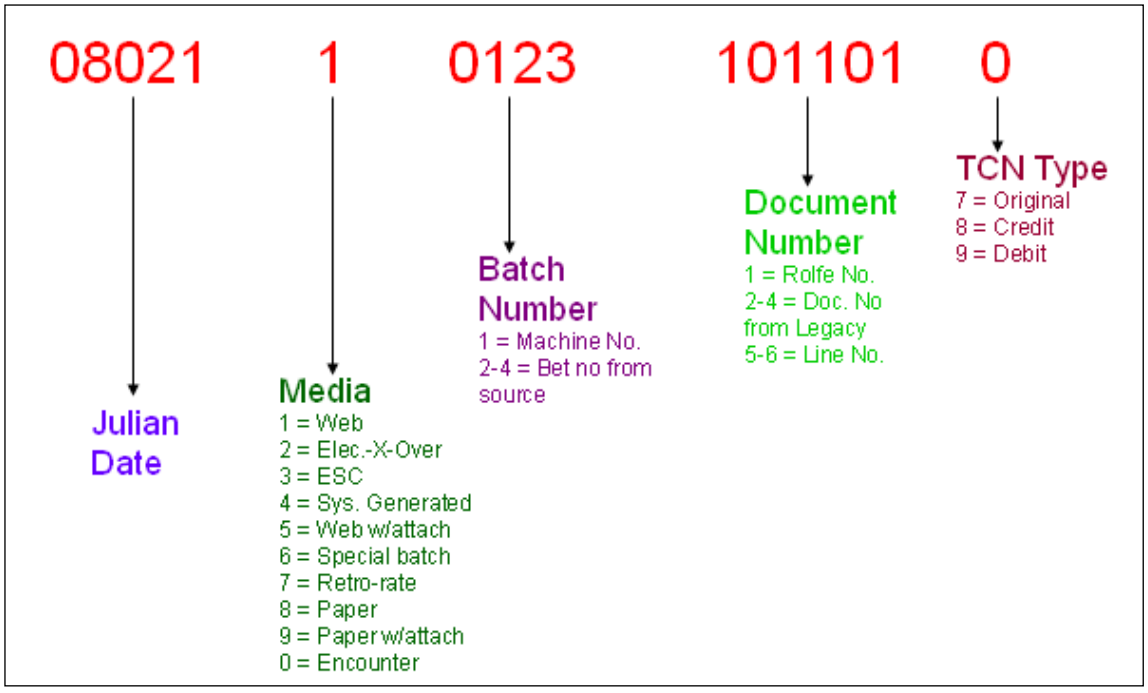
Any claim that is RTP'd will be accompanied by an RTP letter. If the claim was submitted as a paper, the original claim can be corrected. If the claim was originally submitted electronically, it can be resubmitted electronically or be transferred to paper for resubmission.

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.

Conduent 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 Conduent 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 Conduent 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

Conduent 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 Conduent 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 Conduent Provider Inquiry 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 REIMBURSEMENT

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.

HHII		
HCPCS code and Description	**Acuity 1** Case Management	**Acuity 2** Case Management
U1- Comprehensive care management	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
U7 care plan incentive payment	T2022 – U7	T2023 – U7
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 month will be adjudicated as PMPM, subsequent claims will receive a denied status with a PMPM exception code. Providers may opt to submit monthly reports as an alternative to the monthly 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 Conduent 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

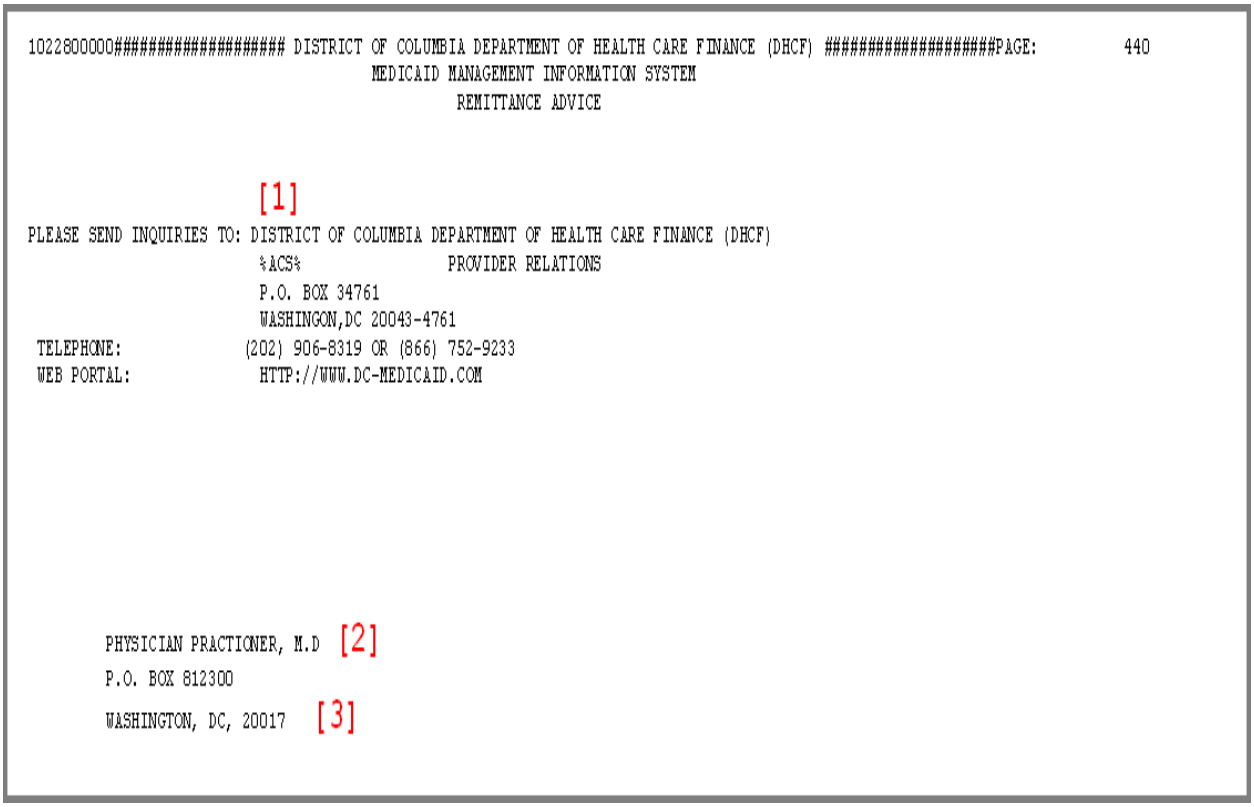
Under the My Health GPS program, approved My Health GPS providers may deliver My Health GPS services remotely. Subsequent to the initial needs assessment, which must be conducted in-person, the My Health GPS program will reimburse for service delivery via audio/video/telephonic connection. These remote options (audio/video/telephonic) can only be used with the appropriate U2-U6 modifiers and 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 (DHCF) ####################PAGE: 440
MEDICAID MANAGEMENT INFORMATION SYSTEM
REMITTANCE ADVICE

[1]

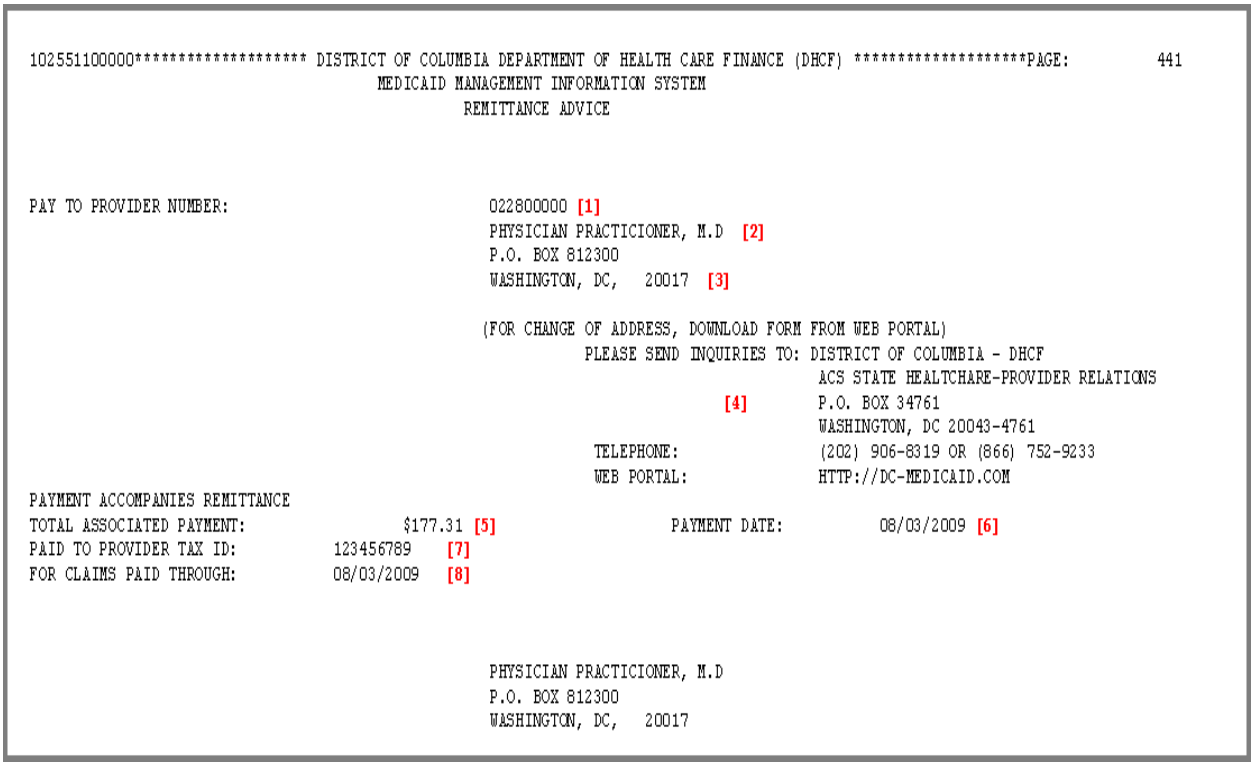
PLEASE SEND INQUIRIES TO: DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF)
%ACS% PROVIDER RELATIONS
P.O. BOX 34761
WASHINGON,DC 20043-4761
TELEPHONE: (202) 906-8319 OR (866) 752-9233
WEB PORTAL: HTTP://WWW.DC-MEDICAID.COM

PHYSICIAN PRACTICNER, 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



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1025511000000********************* DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF) ********************PAGE:          441
                                  MEDICAID MANAGEMENT INFORMATION SYSTEM
                                           REMITTANCE ADVICE



PAY TO PROVIDER NUMBER:                    022800000 [1]
                                           PHYSICIAN PRACTICIONER, 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 HEALTCHARE-PROVIDER RELATIONS
                                                                 [4]          P.O. BOX 34761
                                                                              WASHINGTON, DC 20043-4761
                                                     TELEPHONE:               (202) 906-8319 OR (866) 752-9233
                                                     WEB PORTAL:              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 PRACTICIONER, 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
PLEASE SEND INQUIRES TO	4	Fiscal Agent Services Name/Address/City/State/Zip, contact phone number and the Web Portal address.

FIELD NAME	Field #	DESCRIPTION
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

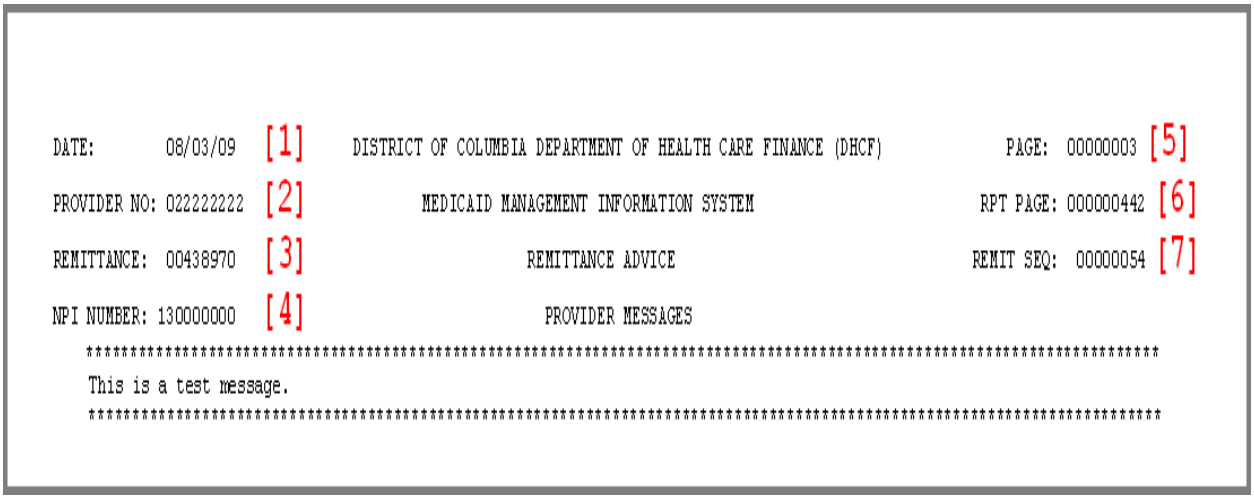


Table 3: Remittance Advice Provider Messages Table

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

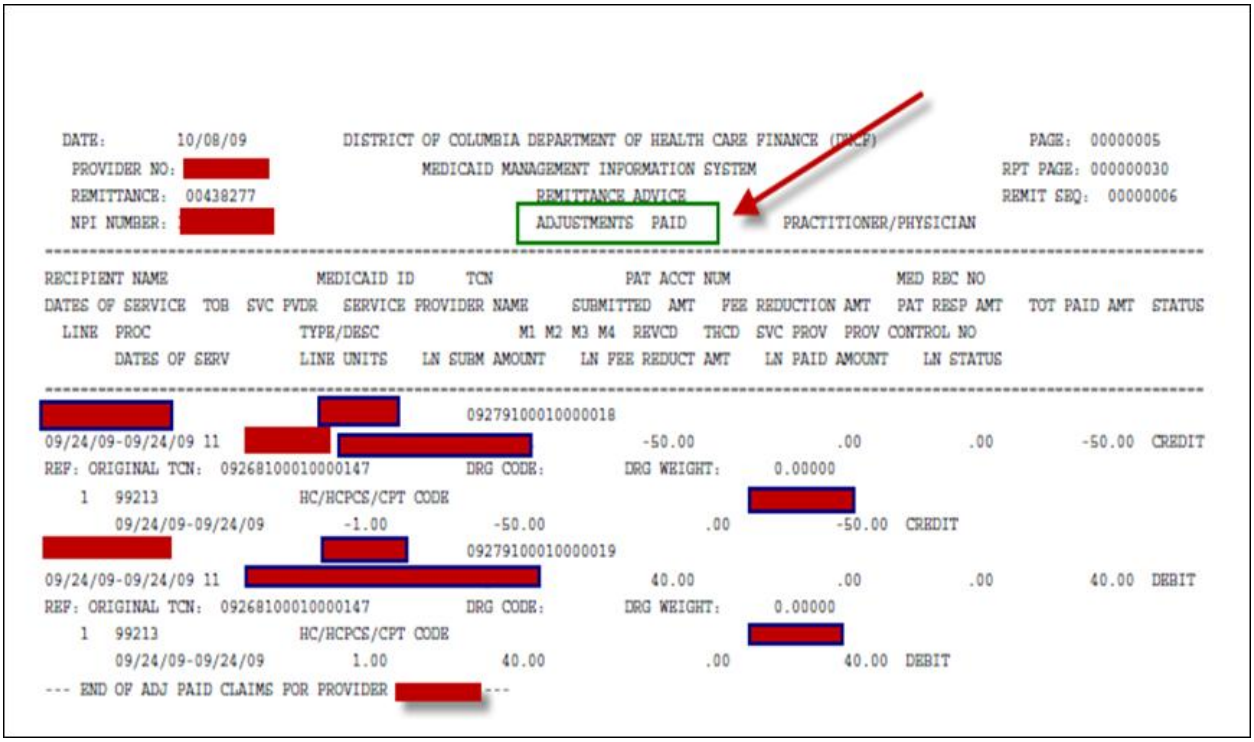


Table 4: Remittance Advice Paid Claims Table

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.

FIELD NAME	Field #	DESCRIPTION
DATES OF SERV	6	First and last dates of service for this claim
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.

FIELD NAME	Field #	DESCRIPTION
FEE REDUCTION AMT	26	The difference between the submitted amount and the paid amount
LN PAID AMOUNT	27	Amount paid for this line item
LN STATUS	28	The line item status

Figure 6: Remittance Advice Adjustments

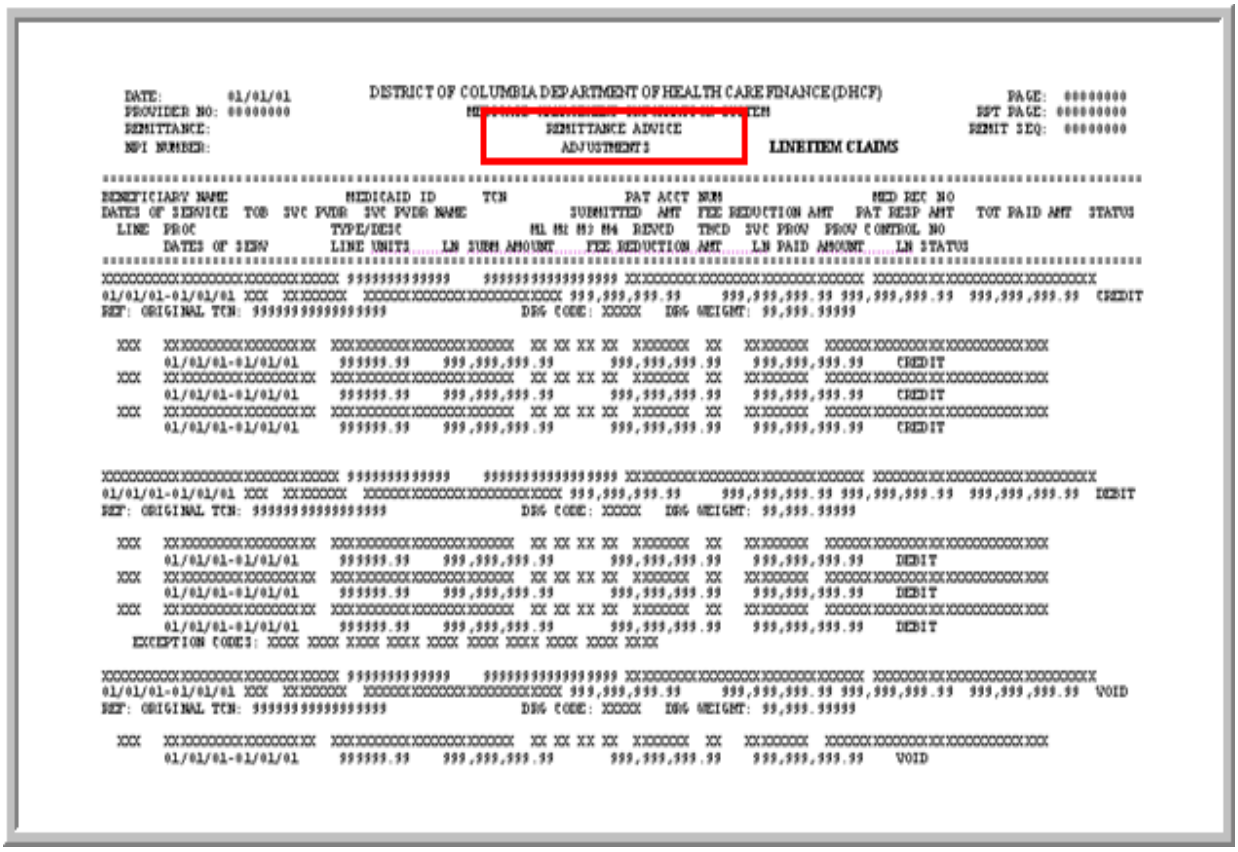


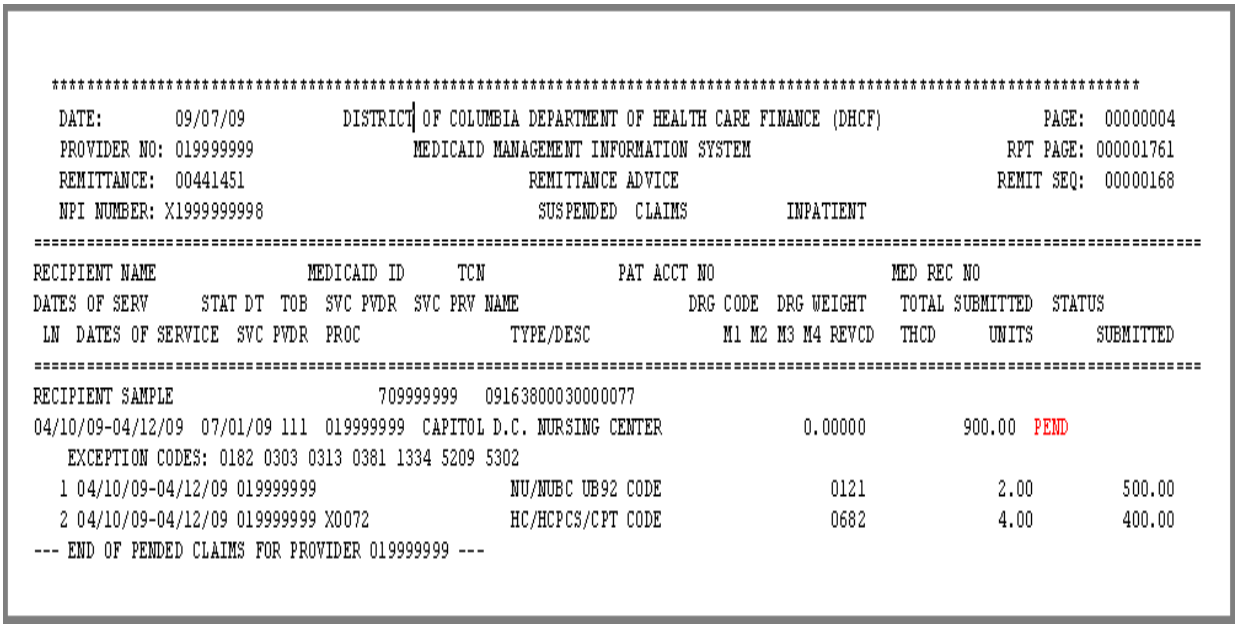
Table 5: Remittance Advice Adjustments Table

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 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 changes 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

Field Name	Description
LN SUBM AMOUNT	The line item submitted amount.
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



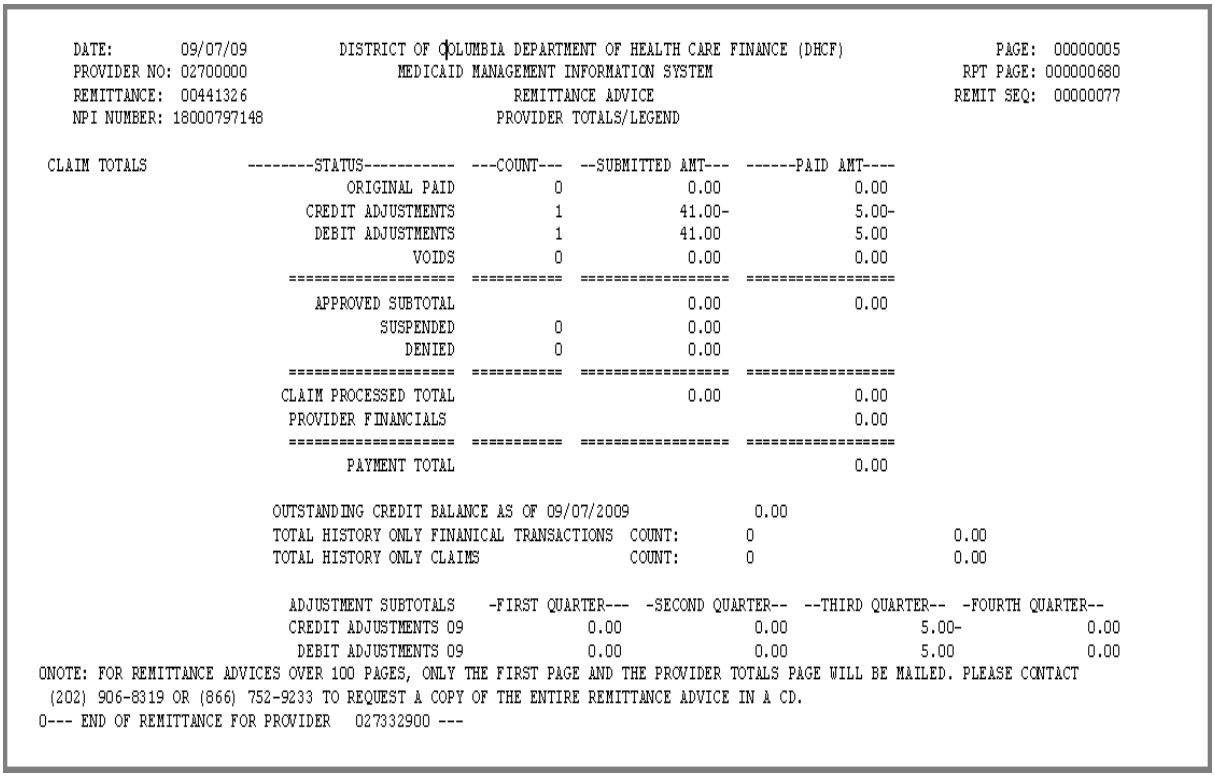
```
*****************************************************************************************************************************************
 DATE:       09/07/09          DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF)                PAGE:  00000004
 PROVIDER NO: 019999999              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
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.

FIELD NAME	DESCRIPTION
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 FINANICAL 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

FIELD NAME	DESCRIPTION
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
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 balance.
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.

FIELD NAME	DESCRIPTION
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:

Code	Definition
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.

- CMS1500l: 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

APPENDIX: ADDRESS AND TELEPHONE NUMBER DIRECTORY

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

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

Claim Status Information/Claims Payment Information
Conduent
District Medicaid Claims Processing Fiscal Agent
P.O. Box 34734
Washington, DC 20043
Attention: Provider Inquiry Unit

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

Claim Submission Information - Mail
For CMS-1500s:
Conduent
District Medicaid Claims Processing
P. O. Box 34768
Washington, DC 20043

For Adjustments and Voids:
Conduent
District Medicaid Claims Processing
P. O. Box 34706
Washington, DC 20043

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

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

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

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

Fraud Hotline
(877) 632-2873

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

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

Magellan 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

Medicaid Payment Schedule Information
Conduent, 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

APPENDIX: 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.

XV. Glossary

Assigned	Beneficiary has been assigned 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.
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 under the current consent event for one of the following reasons: a) he/she no longer meets the eligibility requirements; or b) the beneficiary is in an "inactive" status and case review recommendation is to disenroll.
Enrolled	Beneficiary has signed consent and a claim has been received for the first comprehensive care management service (i.e. care plan developed).
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 on October 1st and ending on September 30th.
Health Care Acquired Condition (HCAC)	A Health care acquired condition is a condition not present upon admission in any inpatient setting, but subsequently acquired in that setting and could reasonably have been prevented through the application of evidence-based guidelines.
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.
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.

Termed	Beneficiary is no longer currently Medicaid eligible.
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.
Adverse Event	An injury/harm/unexpected death that occurs in the course of a beneficiary receiving health care services from a practitioner/provider.
Critical Incident	A Critical Incident is a retrospective review of clinical quality of care issue(s) that has caused serious harm and/or injury that is discovered and meets the definition of a sentinel event.
Sentinel Event	A Patient Safety Event that reaches a patient and results in any of the following: o Death o Permanent harm o Severe temporary harm and intervention required to sustain life An event can also be considered sentinel event even if the outcome was not death, permanent harm, severe temporary harm and intervention required to sustain life. Such events are called "sentinel" because they signal the need for immediate investigation and response.
Never Event	An event that should never occur, despite human error in a healthcare facility. It is an error in medical care that is clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a healthcare facility (as defined by National Quality Forum [NQF]). A sentinel event may be included in the list of Never Events.

APPENDICES

APPENDIX A:
FORMS

Insert Your Logo Here

Consent to Participate in the *My Health GPS* Program

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
_____	_____
Parent/Guardian/ Legal Rep Signature (If Applicable)	Today's Date

Insert Your Logo Here

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

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

El GPS de mi Salud GPS 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 desease 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 cuidad 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

MY HEALTH GPS
OPT OUT FORM

TO BE COMPLETED BY/FOR BENEFICIARIES

If you do not want to participate in the *My Health GPS* Program, please complete the form below and return to DHCF by email: myhgps@dc.gov; or by mail: 441 4th St, NW, Suite 900 South, Washington, DC 20001.

Date _____

Name of Beneficiary:	Date of Birth:	Medicaid Number:
Current *My Health GPS* Program:	Managed Care Organization (MCO) if applicable:	

I do not want to join the *My Health GPS* program at this time. I know that I can choose to participate in *My Health GPS,* at any time, if I am eligible for the program.

Beneficiary or Legal Guardian Name (Please Print)	If Legal Guardian's Signature, print name	Date Signed

FOR DHCF USE ONLY

Date Form Received:	Date Opt Out effective:	Date Beneficiary Notified:

MY HEALTH GPS
PROVIDER CHANGE FORM

TO BE COMPLETED BY/FOR *MY HEALTH GPS* BENEFICIARIES

The *My Health GPS* Provider Change Form must be completed in full. Please complete the form and submit by secure email to myhgps@dc.gov.

Date _____

Name of Beneficiary:	Date of Birth:	Medicaid Number:
Current *My Health GPS* Provider:	Managed Care Organization (MCO) if applicable:	

I understand that I may request to change providers at any time and that the request to change providers will be effective 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.

I understand that I remain eligible to receive *My Health GPS* services from my current *My Health GPS* provider until the effective enrollment date with my new provider.

Signature of Beneficiary or Legal Guardian (if applicable)	If Legal Guardian's Signature, print name	Date Signed

FOR DHCF USE ONLY

Date Form Received:	Effective Date of New MHGPS Assignment:	Date Beneficiary Notified:

MY HEALTH GPS
WITHDRAWAL OF CONSENT FORM

TO BE COMPLETED BY *MY HEALTH GPS* BENEFICIARIES AND PROVIDERS

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

Beneficiary *(Please Initial)*

When you do not want to participate in the *My Health GPS* program any longer, you need to know that:	
	Any *My Health GPS* 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.

Signature of Beneficiary or Legal Guardian (if applicable)	**If Legal Guardian's Signature, print name**	**Date Signed**

MY HEALTH GPS PROVIDER

☐ 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. **By telephone** ☐

Signature of the *My Health GPS* Provider:	**Name of *My Health GPS* Care Provider:**	**Date Signed**

FOR DHCF USE ONLY

Date Form Received:	Effective Date of Withdrawal:	Date Beneficiary Notified:

Please submit completed form by secure email to myhgps@dc.gov.

APPENDIX B:
MONTHLY REPORTING TEMPLATES

Beneficiary Team Assignment

This form will allow DHCF to track the number of beneficiaries being served by each Team to ensure compliance with the regulatory requirements. The completed templates should be submitted no later the 5th day of each month.

DHCF will send each entity a list of their assigned beneficiaries in an excel spreadsheet. The fields that will be auto populated by DHCF and those requiring completion by the entity are in the table below.

Beneficiary Team Assignment Instructions		
*** All the Fields are Mandatory ***		
*** Do not alter or delete any columns ***		
Column	**Field Names**	**Directions**
A	Beneficiary_ID	Column to auto populated by DHCF
B	Last Name	Column to auto populated by DHCF
C	First Name	Column to auto populated by DHCF
D	DOB	Column to auto populated by DHCF
E	Gender	Column to auto populated by DHCF
F	Health Home Provider ID	Column to auto populated by DHCF
G	Health Home Provider Name	Column to auto populated by DHCF
H	Recipient Acuity Level	Column to auto populated by DHCF
L	City	Column to auto populated by DHCF
M	State	Column to auto populated by DHCF
Columns I - K and N - P are to be completed by the *My Health GPS* Entity:		
I	Site Name	Indicate the My Health GPS site to which the beneficiary is assigned. Insert N/A if not applicable.
J	Site Address 1	Insert the street address of the site referenced in column I.
K	Site Address 2	Insert additional address components, e.g. suite number, Floor number, etc. of the site referenced in column I.
N	Zip Code	Insert the zip code of the site referenced in column I.
O	Phone Number	Insert the phone number of the site referenced in column I.
P	Team Name	Insert the team name.

Services

A monthly report from the My Health GPS entity's electronic health record on the services provided to beneficiary will start October 1, 2017. More guidance and a template will be forthcoming.

Staffing Changes

This form will allow DHCF to track the staffing of each Team to ensure compliance with the regulatory requirements. The completed templates can be submitted at any time when a staff change occurs or on a monthly basis by the 10th day of the month.

DHCF will send each entity an excel spreadsheet to record their staffing information. The fields that will be auto populated by DHCF and those requiring completion by the entity are in the table below.

Staffing Plan Template Instructions		
*** All the Fields are Mandatory *** *** Do not alter or delete any columns ***		
Column	**Field Names**	**Directions**
A	Entity Unique ID	Column A will be auto populated by DHCF
Columns B - I are to be completed by the *My Health GPS* Entity:		
B	Site Name	Indicate the My Health GPS site to which staff is assigned. Insert N/A if not applicable.
C	Team Acuity Level (Drop Down Menu)	Indicate the whether the Team is for high or low acuity beneficiaries.
	Group 1 (Low Acuity)	
	Group 2 (High Acuity)	
D	Team Name	Insert the team name.
E	Staff First Name	Insert the first name of staff member.
F	Staff Last Name	Insert the last name of staff member.
G	Staff Designation (Drop Down Menu)	Designate the position on the My Health GPS team.
	Health Home Director	
	Nurse Care Manager	
	Peer Navigator/Community Health Worker	
	Care Coordinator/Bachelor Social Worker	
	Clinical Pharmacist	
H	Staff Status (Drop Down Menu)	
	New Staff	Use when bringing on new My Health GPS staff members.
	Change in Role or Level of Effort	Use to designate the new role of an existing My Health GPS staff member or to change the level of effort of an existing My Health GPS staff member.
	Former Staff	Indicate the staff member that will no longer be part of the team.
I	Full-Time Equivalent %	Document the FTE % for each staff person.

APPENDIX C:
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. We would expect you adhere to the clinical standards and guidance for the particular assessment
Attribution		
1	How will new patients to a practice be eligible for attribution?	After the initial attribution, there will be quarterly attributions. If a beneficiary does not have a prior relationship with a HH provider, the beneficiary will be auto-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?	Patients have freedom of choice and can switch providers. If a patient formally switches, it will be captured by DHCF. My Health GPS can only bill for Health Home services for beneficiaries formally linked to them.
3	Could you say a few words about your attribution methodology? What is the primary way that a patient gets associated with a provider?	The attribution looks at the facilities eligible beneficiaries received primary care services. The primary care services are identified by both provider type and a set of evaluation and management codes.
4	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.
Billing		
1	If a provider is submitting a *MyHealthGPS* claim for an MCO beneficiary and also delivers a medical service on the same day, does the provider send one claim to the MCO and one claim to DHCF?	Yes
2	Will the care plan incentive be paid based on date of service or billing date?	Date of Service
Care Plan		
1	Many our MHGPS patients are already in the care of nurse care manager here, owing to our HIV program. 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.
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."
3	How are care plans to 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	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 DHCF will need to see that all required assessment fields were conducted, but the assessment information can live

Issue	Question	Response
	purchased) or does DCHF wish to have all the elements in a stand-alone "document"?	elsewhere in the EHR.
Consent		
1	My Health GPS 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?	DHCF pays the same Group 1 or Group 2 rate directly to My Health GPS providers for all My Health GPS beneficiaries.
NCQA		
1	What is the required timeline for receiving NCQA Level 2 PCMH recognition?	My Health GPS providers must achieve Level 2 recognition, or future NCQA PCMH equivalent level recognition, within 12 months of the date of submission of the My Health GPS 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		
	What is the best way to propose an alternative staffing model?	DHCF 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 My Health GPS program?	Providers may deliver some My Health GPS services remotely. The initial needs assessment must be in-person. One Group 2 service must be delivered face-to-face.
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.
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 My Health GPS service was completed (and, of course, a care plan has been developed).