


**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
**Department of Health Care Finance**



Office of the Senior Deputy Director/Medicaid Director

**Transmittal # 17-08**

**TO:** All District of Columbia Medicaid Providers

**FROM:** Claudia Schlosberg, J.D.   
Senior Deputy Director and State Medicaid Director

**DATE:** March 1, 2017

**SUBJECT:** My Health GPS Application

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The purpose of this transmittal is to provide the application to be used by primary care providers currently enrolled in DC Medicaid and interested in delivering services under the My Health GPS program. The My Health GPS program is a care coordination benefit for Medicaid beneficiaries with multiple chronic conditions, enrolled in either Fee-For-Service or Managed Care. The My Health GPS program aims to reduce preventable hospital admissions and emergency department visits and improve health outcomes. The My Health GPS program will utilize interdisciplinary teams embedded in the primary care setting to integrate and coordinate the full array of services to eligible beneficiaries, including: primary care, acute care, behavioral health, and long-term care services and supports.

**My Health GPS Application**

The *My Health GPS* application is available on the DHCF website at: <https://dhcf.dc.gov/page/health-home-persons-multiple-chronic-conditions-my-health-gps>. This application will be reviewed by DHCF to determine an entity's eligibility to provide services under the My Health GPS program. The written application packet must be completed in its entirety. Failure to submit a complete application, including copies of all necessary documents will delay processing of your written application.

**Due Date**

The initial application period is between March 1, 2017 and March 31, 2017. Applications are due by 5:00 PM on March 31, 2017 in order to be eligible for beneficiary assignments for the start of the program on July 1, 2017.

After March 31, 2017, applications will be accepted and reviewed on an ongoing basis.

**Submission**

Return the completed and signed written application and required documents via email at [MyHGPS@dc.gov](mailto:MyHGPS@dc.gov), using your organization's name in the subject line.

**Questions**

Any questions regarding the My Health GPS program should be submitted by email to [joe.weissfeld@dc.gov](mailto:joe.weissfeld@dc.gov).

cc: Medical Society of the District of Columbia  
DC Hospital Association  
DC Primary Care Association  
DC Health Care Association  
DC Home Care Association  
DC Behavioral Health Association  
DC Coalition of Disability Service Providers

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
**Department of Health Care Finance**



Dear Provider:

Enclosed is the application to be used by primary care providers currently enrolled in DC Medicaid and interested in delivering services under the My Health GPS program. The My Health GPS program is a care coordination benefit for Medicaid beneficiaries with multiple chronic conditions, enrolled in either Fee-For-Service or Managed Care. The My Health GPS program aims to improve health outcomes and reduce preventable hospital admissions and emergency department visits and. The My Health GPS program will utilize interdisciplinary teams embedded in the primary care setting to integrate and coordinate the full array of services to eligible beneficiaries, including: primary care, acute care, behavioral health, and long-term care services and supports.

**My Health GPS Application**

This application will be reviewed by DHCF to determine an entity's eligibility to provide services under the My Health GPS program. The written application packet must be completed in its entirety. Failure to submit a complete application, including copies of all necessary documents will delay processing of your written application.

**Due Date**

The initial application period is between March 1, 2017 and March 31, 2017. Applications are due by 5:00 PM on March 31, 2017 in order to be eligible for beneficiary assignments for the start of the program on July 1, 2017. After March 31, 2017, applications will be accepted and reviewed on an ongoing basis for beneficiary assignments for each subsequent quarter.

**Submission**

Return the completed and signed written application and required documents via email at [MyHGPS@dc.gov](mailto:MyHGPS@dc.gov), using your organization's name in the subject line.

**Questions**

Any questions regarding the My Health GPS program should be submitted by email to [joe.weissfeld@dc.gov](mailto:joe.weissfeld@dc.gov).

Sincerely,

DHCF Health Home Support Team

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
**Department of Health Care Finance**



<b>MY HEALTH GPS ENROLLMENT APPLICATION</b>	
<b>PROVIDER INFORMATION</b>	
<b>Entity Name:</b> Click here to enter text.	<b>Clinical Practice</b> <input type="checkbox"/> <b>Clinical Group Practice</b> <input type="checkbox"/> <b>Federally Qualified Health Center</b> <input type="checkbox"/>
<b>Address:</b> Click here to enter text.	
<b>City/State:</b> Click here to enter text.	<b>Zip Code:</b> Click here to enter text.
<b>Point of Contact for DHCF:</b> Click here to enter text.	<b>Point of Contact for MCOs:</b> Click here to enter text.
<b>Phone:</b> Click here to enter text.	<b>E-mail:</b> Click here to enter text.
<b>Medicaid ID Number</b> (one per application): Click here to enter text.	<b>National Provider Identifier (NPI) Number</b> (one per application): Click here to enter text.
<b>REQUIRED DOCUMENTATION:</b>	
Utilize the templates included in the written application packet or submit contracts, where appropriate as attachments to your application	
<b>National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH):</b> Please complete the attached template to attest to receipt of Level 2 recognition (or future corresponding NCQA PCMH equivalent level recognition) or proof of beginning the NCQA PCMH application process.	Attachment A
<b>Electronic Health Record:</b> Please attach proof (copy of a contract) that the entity utilizes certified electronic health record (EHR) technology.	Attachment B
<b>Hospital Alerts:</b> Please complete the attached template to attest to enrollment in the Chesapeake Regional Information System for Patients (CRISP) to receive hospital and emergency department alerts (Encounter Notification Service) for enrolled beneficiaries.	Attachment C
<b>24/7 Access to Clinical Advice:</b> Please attach proof (copy of a contract) that the entity offers twenty-four hour, seven day per week access to clinical advice, including culturally appropriate translation and interpretation services for beneficiaries with limited English proficiency.	Attachment D
<b>Organizational Chart:</b> Please attach your entity's organizational chart to support the My Health GPS program.	Attachment E

## CARE APPROACH

**Description of Care Approach:** Please provide a detailed description of your approach to conduct outreach and deliver care under the My Health GPS program, including tools used to support care planning and coordination. The narrative should include your processes used to perform the functions described below in items 1 - 8 (1,000 words or less). [Click here to enter text.](#)

- (1) Provide quality-driven, cost-effective, culturally appropriate, and person-centered services;
- (2) Coordinate and provide access to high-quality healthcare services informed by evidence-based clinical practice guidelines;
- (3) Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
- (4) Coordinate and provide access to mental health and substance abuse services;
- (5) Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings, including discharge planning and facilitation of transfers from pediatric to adult care settings;
- (6) Coordinate and provide access to long-term care supports and services;
- (7) Develop a person-centered care plan for each beneficiary that coordinates and integrates all clinical and non-clinical healthcare-related needs and services;
- (8) Establish a continuous quality improvement program.

**Description of Alignment Across Entities:** If applicable, please describe your approach to coordinating care across entities within your organization. If some entities within your organization will not enroll in the My Health GPS program, describe how you will coordinate with them. [Click here to enter text.](#)

**Enrollment Projections:** To help DHCF better understand ongoing provider capacity for purposes of identifying future needs, such as providing technical support and establishing budgets, please provide the anticipated number of beneficiaries to be served by your entity by the end of the first quarter [Click here to enter text.](#); fourth quarter [Click here to enter text.](#); and eighth quarter: [Click here to enter text.](#)

**Staffing Ramp-Up Plan:** If the entity does not meet the minimum staffing ratios as of the date of submission of this application, please describe the plan to comply with the minimum staffing ratios within the first two quarters of the program. [Click here to enter text.](#)

### STAFFING INFORMATION

Complete the following information about your My Health GPS provider/staff team(s). At a minimum, entities must identify one complete Group 1 team for the application to be considered. To add additional teams as part of this application, please use Supplemental Form A available at [www.dhcf.dc.gov](http://www.dhcf.dc.gov). To add additional teams at a later date, please use the Supplemental Form B available at [www.dhcf.dc.gov](http://www.dhcf.dc.gov).

#### Team 1:

Group 1 (Lower Acuity):	Group 2 (Higher Acuity):
<p><b>Health Home Director</b> <small>Click here to enter text.</small>                      Highest education obtained: <small>Click here to enter text.</small>                      List of license(s), if applicable: <small>Click here to enter text.</small>                      Years of relevant experience: <small>Click here to enter text.</small>                      Full-Time Equivalent (FTE): <small>Click here to enter text.</small>  <u>Minimum staffing ratio is 0.5 FTE per 400 beneficiaries</u></p>	<p><b>Health Home Director</b> <small>Click here to enter text.</small>                      Highest education obtained: <small>Click here to enter text.</small>                      List of license(s), if applicable: <small>Click here to enter text.</small>                      Years of relevant experience: <small>Click here to enter text.</small>                      Full-Time Equivalent (FTE): <small>Click here to enter text.</small>  <u>Minimum staffing ratio is 0.5 FTE per 400 beneficiaries</u></p>
<p><b>Nurse Care Manager</b> <small>Click here to enter text.</small>                      Highest education obtained: <small>Click here to enter text.</small>                      List of license(s), if applicable: <small>Click here to enter text.</small>                      Years of relevant experience: <small>Click here to enter text.</small>                      Full-Time Equivalent (FTE): <small>Click here to enter text.</small>  <u>Minimum staffing ratio is 1 FTE per 400 beneficiaries</u></p>	<p><b>Nurse Care Manager</b> <small>Click here to enter text.</small>                      Highest education obtained: <small>Click here to enter text.</small>                      List of license(s), if applicable: <small>Click here to enter text.</small>                      Years of relevant experience: <small>Click here to enter text.</small>                      Full-Time Equivalent (FTE): <small>Click here to enter text.</small>  <u>Minimum staffing ratio is 2 FTE per 400 beneficiaries</u></p>
N/A	<p><b>Care Coordinator</b> <small>Click here to enter text.</small>                      Highest education obtained: <small>Click here to enter text.</small>                      List of license(s), if applicable: <small>Click here to enter text.</small>                      Years of relevant experience: <small>Click here to enter text.</small>                      Full-Time Equivalent (FTE): <small>Click here to enter text.</small>  <u>Note: Minimum staffing ratio is 2 FTE per 400</u></p>
<p><b>Peer Navigator</b> <small>Click here to enter text.</small>                      Highest education obtained: <small>Click here to enter text.</small>                      List of license(s), if applicable: <small>Click here to enter text.</small>                      Years of relevant experience: <small>Click here to enter text.</small>                      Full-Time Equivalent (FTE): <small>Click here to enter text.</small>  <u>Minimum staffing ratio is 1 FTE per 400 beneficiaries</u></p>	<p><b>Peer Navigator</b> <small>Click here to enter text.</small>                      Highest education obtained: <small>Click here to enter text.</small>                      List of license(s), if applicable: <small>Click here to enter text.</small>                      Years of relevant experience: <small>Click here to enter text.</small>                      Full-Time Equivalent (FTE): <small>Click here to enter text.</small>  <u>Minimum staffing ratio is 3.5 FTE per 400 beneficiaries</u></p>
N/A	<p><b>Clinical Pharmacist</b> <small>Click here to enter text.</small>                      Highest education obtained: <small>Click here to enter text.</small>                      List of license(s), if applicable: <small>Click here to enter text.</small>                      Years of relevant experience: <small>Click here to enter text.</small>                      Full-Time Equivalent (FTE): <small>Click here to enter text.</small>  <u>Minimum staffing ratio is 0.5 FTE per 400 beneficiaries</u></p>

**ATTESTATIONS**

The entity shall respond to the following questions by selecting yes or no.

Does the entity or any proposed staff identified in this application have pending investigations, exclusions, suspensions, or debarment from any federal or DC health care program, or any overpayment from DHCF?

Yes  No

The entity has the capacity to: 1) deliver core Health Home services and document the services; 2) directly provide, or subcontract for the provision of, Health Home services; and 3) establish and maintain communication protocols with external health care partners.

Yes  No

The entity understands the information outlined in this application is subject to audit.

Yes  No

The entity understands that enrollment is contingent on passing a DHCF readiness review, which shall be conducted on-site for entities that have not yet received NQCA PCMH Level 2 recognition.

Yes  No

The entity understands that DHCF will provide a standard consent form for the My Health GPS program. Any addenda must be submitted to DHCF for review and approval prior to the start of the program.

Yes  No

The entity understands that it is a requirement to update this application by submitting an addendum to reflect changes to any portion of this application within 30 days of the change.

Yes  No

The entity attests that all information provided in this application is accurate.

Yes  No

**ENTITY SIGNATURE**

Signature of Authorized Personnel:

**Print:**

Click here to enter text.

**Title:** Click here to enter text.

**Date:** Click here to enter a date.

# **ATTACHMENTS:**

REQUIRED DOCUMENTATION



**ATTACHMENT A: Patient-Centered Medical Home (PCMH)**

Please complete the attached template to attest to receipt of Level 2 recognition (or future corresponding NCQA PCMH equivalent level recognition) or proof of beginning the NCQA PCMH application process.

National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH)		
<b>Entity Name:</b> <a href="#">Click here to enter text.</a>		
<b>Current Recognition:</b> PCMH 2011: Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 3 <input type="checkbox"/> PCMH 2014: Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 3 <input type="checkbox"/> PCMH 2017: <input type="checkbox"/> None: <input type="checkbox"/> (skip to application status section)		
CURRENT RECOGNITION DATE RANGE		
<b>Recognition Start Date:</b> <a href="#">Click here to enter a date.</a>	<b>Recognition End Date:</b> <a href="#">Click here to enter a date.</a>	
APPLICATION STATUS		
<b>Application Submitted:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Submission Date:</b> <a href="#">Click here to enter a date.</a>	
<b>Purchase of Survey Tool:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Purchase Date:</b> <a href="#">Click here to enter a date.</a>	
<b>Purchase of Survey Tool Confirmation:</b> Please attach an email confirmation verifying the purchase of the survey tool.		
<b>Achievement of NCQA Recognition:</b> The entity understands that NCQA PCMH Level 2 recognition or future corresponding PCMH equivalent level recognition must be achieved within twelve months of the date of submission of the My Health GPS application: Yes <input type="checkbox"/> No <input type="checkbox"/>		
ENTITY SIGNATURE		
The entity's signature authorizes DHCF to confirm the accuracy of this information with NCQA		
Signature of Authorized Personnel:  Print:  <a href="#">Click here to enter text.</a>	<b>Title:</b> <a href="#">Click here to enter text.</a>	<b>Date:</b> <a href="#">Click here to enter a date.</a>

**ATTACHMENT B: Electronic Health Record**

Please attach proof (copy of a contract) that the entity utilizes certified electronic health record (EHR) technology.

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**ATTACHMENT C: Hospital Alerts**

Please complete the attached template to attest to enrollment in the Chesapeake Regional Information System for Patients (CRISP) to receive hospital and emergency department alerts (Encounter Notification Service) for enrolled beneficiaries.

Chesapeake Regional Information System for Patients (CRISP)		
<b>Entity Name:</b> <a href="#">Click here to enter text.</a>		
<b>Current CRISP Encounter Notification Service (ENS) Enrollment:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		
CURRENT ENROLLMENT DATE RANGE		
<b>Enrollment Start Date:</b> <a href="#">Click here to enter a date.</a>		
ENTITY'S SIGNATURE		
The entity's signature authorizes DHCF to confirm the accuracy of this information with CRISP		
<b>Signature of Authorized Personnel:</b>  <b>Print:</b>  <a href="#">Click here to enter text.</a>	<b>Title:</b> <a href="#">Click here to enter text.</a>	<b>Date:</b> <a href="#">Click here to enter a date.</a>

**ATTACHMENT D: 24/7 Access to Clinical Advice**

Please attach proof (copy of a contract) that the entity offers twenty-four hour, seven day per week access to clinical advice, including culturally appropriate translation and interpretation services for beneficiaries with limited English proficiency.

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**ATTACHMENT E: Organizational Chart**

Please attach your entity's organizational chart to support the My Health GPS program.

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