GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Director

October 5, 2020

To: All District Medicaid Providers

Re: Continuity of Care for Beneficiaries in Managed Care and Provider Reimbursement

The Department of Health Care Finance (DHCF) contracts with Medicaid managed care organizations (MCOs) to provide health services to Medicaid and Alliance beneficiaries. On October 1, 2020, DHCF entered into new contracts with three MCOs: AmeriHealth Caritas DC; MedStar Family Choice DC; and CareFirst Community Health Plan DC (formerly known as Trusted Health Plan).

The Medicaid managed care program, DC Healthy Families, is officially in a transition period between October 1, 2020 and December 31, 2020. During this time, continuity of care (COC) is priority and there are COC requirements to ensure access to on-going care is seamless. This is particularly relevant with the new contracts as beneficiaries are either transitioning from one MCO to another or one service delivery system to another (i.e., fee-for-service to managed care).

During the transition period, MCOs will reimburse for services rendered to covered beneficiaries regardless of your contracted status with the MCO. Prior authorizations and prescriptions are also honored if issued prior to October 1, 2020. Providers are expected to maintain scheduled appointments between now and December 31, 2020, and providers can expect to be reimbursed for services provided. Additional details are provided below.

Continuity of Care Requirements

DHCF has instituted the following COC provisions:

- **Health care providers should not cancel appointments with current patients.** MCOs must honor any ongoing treatment that was authorized prior to the recipient's enrollment into the MCO for up to 90 days after the transition.
- **Providers will be paid.** Providers should continue providing any services that were previously authorized, regardless of whether the provider is participating in the MCO's network. MCOs must pay for previously authorized services at the rate previously received for at least 90 days after the transitions.

- **Providers will be paid promptly.** During the continuity of care period, MCOs are required to follow all timely claims payment contractual requirements. DHCF will monitor complaints to ensure that any issues with delays in payment are resolved.
- **Prescriptions will be honored.** MCOs must allow recipients to continue to receive their prescriptions through their current provider, for up to 90 days after the transition, until their prescriptions can be transferred to a provider in the MCO's network.

MCO Responsibilities

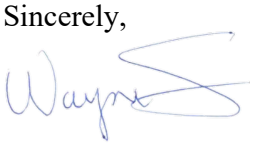
If a beneficiary was receiving a service prior to moving to a new MCO, including those services previously authorized under the fee-for-service delivery system, the enrollee's new MCO must continue to provide that service for up to 90 days after transition. The new MCO cannot require any additional forms of authorization and cannot require that the services be provided by a participating (in network) provider. These expectations are outlined in a joint MCO letter that is available online at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/images/FY21%20MCO%20Provider%20Reimbursement%20.pdf.

In addition, the following services may extend beyond the 90-day COC period:

- Personal Care Aide (PCA) Services shall continue until the enrollee receives their annual comprehensive assessment or a change in condition results in a new plan of care being developed, and services are authorized and arranged as required to address the long term care needs of the enrollee.
- Prenatal and postpartum care for the entire course of pregnancy including postpartum care (six weeks after birth).
- Transplant Services for one-year post-transplant.
- Oncology services including radiation and/or chemotherapy services for the duration of the current round of treatment.
- Full course of treatment of therapy for Hepatitis C treatment drugs.

If you have MCO-specific questions, the points of contact are provided in the joint MCO letter referenced above. All other questions may be addressed to Lisa Truitt at lisa.truitt@dc.gov or Melisa Byrd at melisa.byrd@dc.gov.

Sincerely,



Wayne Turnage
Deputy Mayor for Health and Human Services
Director Department of Health Care Finance

Melisa Byrd

Melisa Byrd
Deputy Director/Medicaid Director

Cc: Karen Dale, AmeriHealth Caritas DC
George Aloth, CareFirst Community Health Plan DC
Leslie Lyles Smith, MedStar Family Choice DC

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Provider Frequently Asked Questions for Managed Care

***Health care providers should not cancel appointments with current patients. MCOs must honor any ongoing treatment that was authorized prior to the recipient's enrollment into the MCO for up to 90 days (December 31, 2020) after the transition.**

****A Friendly Reminder: Please check the enrollee's eligibility status before you provide a service.**

How do I check an enrollee's eligibility status?
To check an enrollee's eligibility please go to https://www.dcmedicaid.com/dcwebportal/home when you are contacted to provide services. If you are unable to verify their eligibility, please refer the beneficiary to DC Healthy Families Helpline at 1(800) 620-7802. If time permits, you can call DC Healthy Families and assist the beneficiary with clarifying their assigned health care plan.

If I provide a service for an enrollee, will I get paid?
Yes, Providers will be paid. Providers should continue providing any services that were previously authorized, regardless of whether the provider is participating in the MCO's network. MCOs must pay for previously authorized services at the rate previously received for at least 90 days after the transitions.

Will the MCOs pay me timely for providing services to their enrollees?
Providers will be paid promptly. During the continuity of care period, MCOs are required to follow all timely claims payment contractual requirements. DHCF will monitor complaints to ensure that any issues with delays in payment are resolved.

Will the enrollee be able to get their prescriptions filled?
Prescriptions will be honored. MCOs must allow recipients to continue to receive their prescriptions through their current provider, for up to 90 days after the transition, until their prescriptions can be transferred to a provider in the MCO's network.

Who do I contact to establish a contract and enroll in an MCOs network?
If you do not have an agreement with these MCOs and wish to enroll in their provider network, please contact the Provider Relations staff or website listed below. Representatives from each organization will answer your questions about joining the MCO's network.

AmeriHealth Caritas District of Columbia
Carl Chapman
Director, Provider Network Management
(215) 840-2943 (Cell)
cchapman@amerihealthcaritasdc.com
https://www.amerihealthcaritasdc.com/provider/index.aspx

CareFirst Community Health Plan District of Columbia
Kenny R. Greene
Vice President External Operations
(202) 441-5223
kenny.greene@carefirstchpdc.com
https://www.carefirstchpdc.com/providers.html

MedStar Family Choice District of Columbia
Jennifer Tse
Director, Provider Networks
(800) 805-1722, Option 5
jennifer.tse@medstar.net
https://www.medstarfamilychoice.com/dc-healthy-families/for-dc-healthy-families-physicians/

How can I get fee schedules for all 3 Managed Care Organizations (MCO) before contracting?
You must contact each MCO to discuss contracting and reimbursement. Providers will need to negotiate reimbursement arrangements with each MCO.

Will each MCO have their own prior authorization process?
Yes, MCOs establish and maintain a prior authorization process. Providers will request prior authorization as required by the MCO. It is the providers' responsibility to verify whether the services and care rendered in their professional disciplines require prior approval. Requests for prior approval must be submitted before a service is rendered, except in cases of emergency.
The MCO must honor existing and active prior authorizations on file with the Department of Health Care Finance or the beneficiary's previous MCO until December 31, 2020 to ensure continuity of care.

Do I need to be credentialed with each MCO?
Yes, in order to provide services to the DC Medicaid managed care population, which will include beneficiaries transitioning from the Fee-for-Service program to Managed Care, providers will need to be enrolled and credentialed with each MCO. If you are currently providing services to beneficiaries who receive their Medicaid services through the FFS program, contact each MCO to explore contracting options.

Will there be a set number of providers per MCO?
No, there are no limitations on the number of providers an MCO may contract with for services.

Do I have to contract with all MCOs?
Federally Qualified Health Centers (FQHCs), acute care hospitals in the District and their affiliated physician groups must have contracts with all MCOs effective October 1, 2020 in order to continue to be a Medicaid provider per the updated provider agreement. All other providers are not required to contract with every MCO; however, providers are encouraged to explore contracting options with each MCO.

Can credentialing be done through CAQH?
Contact each MCO to find out more about credentialing and enrollment.

Will pharmacists be credentialed?
Yes, all pharmacist must go through the MCO credentialing process.

Where can I locate the credentialing information?
Contact each MCO to find out more about credentialing and enrollment.

When will providers need to start contracting with MCOs?
Providers can begin contracting with MCOs at any time. MCOs have started contracting with providers to expand their networks.

What is an example of an excluded population that will continue under Medicaid fee-for-service?
An example of a population excluded from Medicaid Managed Care enrollment is beneficiaries enrolled in one of the Districts Home and Community Based Waivers (Elderly and Persons with Physical Disabilities (EPD) & Intellectual and Developmental Disabilities (IDD) waivers) For a complete understanding of beneficiaries who are mandatory, excluded, exempt from participating in Medicaid managed care, see https://dhcf.dc.gov/node/1491391

Will there be a way to cap the number of Medicaid Managed Care patients per provider?
Providers may address preferred restrictions with the MCO(s) during contracting discussions.

When will the list of the approved MCO's be available to practitioners?
DHCF announced its intent to award contracts to three MCOs on July 16 and are listed at: https://dhcf.dc.gov/release/dhcf-announces-intent-award-medicaid-managed-care-contracts-meet-major-milestone-path. Once the MCO contracts are awarded by the Office of Contracting and Procurement, the information will be available at: https://dhcf.dc.gov/.

Will a beneficiary have to select a primary care provider (PCP) when selecting a MCO? If so, can the beneficiary see any credentialed provider within the practice?
Beneficiaries are encouraged to select a PCP when selecting an MCO. The District's Enrollment Broker (DC Healthy Families) will provide beneficiaries with information and assistance in selecting a PCP at the time of enrollment. Beneficiaries that do not select a PCP when selecting a health plan will automatically be assigned a PCP by their MCO.

Will each MCO have their own portal for checking eligibility, claims, and guidelines or will we still go through the dc-medicaid.com website for this information?
Contact each MCO for more information regarding their provider portal capabilities. Providers are encouraged to use the https://www.dc-medicaid.com/dcwebportal/home eligibility verification function to verify eligibility and managed care enrollment information.

SAMPLES OF ENROLLEE QUESTIONS AND RESPONSES:

An Enrollee just received a letter informing them that they have been auto-assigned to a new MCO. The enrollee is not familiar with Managed Care, what should you do?

Response: Tell the enrollee to call DC Healthy Families Helpline at (202) 639-4030 from Mon. – Fri. 7 a.m. – 8 p.m. and every Sat. of the month from 10 a.m. – 2 p.m.

An Enrollee has been newly auto-assigned to a new health plan that the provider is not a participating provider in the MCO network, what should you do?

Response: Tell the enrollee that they can continue to see their current provider until 12/31/2020. If they have additional questions, they should call DC Healthy Families Helpline at (202) 639-4030.

An Enrollee may ask what they can do to switch their health plans.

Response: Tell them that they have 90-days (10/1/2020-12/31/2020) to decide if they would like to stay with their newly assigned health plan or if they would like to be re-assigned to a new health plan. Instruct the Enrollee to contact the DC Healthy Families Helpline at (202) 639-4030, Mon-Fri from 7 a.m. – 8 p.m. and every Sat. of the month from 10 a.m. – 2 p.m.

An Enrollee will say that they have an appointment or a procedure scheduled next week/month. They want to know if they can still go to this visit or have the procedure?

Response: Tell them Yes! The health plans will honor all prior appointments and scheduled procedures up to the end of 90 day transition period on 12/31/2020. Have the Enrollee contact DC Healthy Families Helpline to assist the enrollee with continuing with their prior health plan.

An Enrollee may ask if they will be charged for services they receive under the new health plans.

Response: No. A Medicaid enrollee will not be charged for any medical services covered under Medicaid.

An Enrollee may ask "What do I do to obtain a refill for my medication?

Response: The enrollee should contact their Member Service at their assigned health plan.