MedStar Family Choice

DISTRICT OF COLUMBIA

Provider Newsletter

1st Quarter 2026

In This Issue

DHCF Department of Health Care Finance

This program is brought to you by the Government of the District of Columbia Department of Health Care Finance.

WE ARE WASHINGTON DC GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR

MFCDC070926

Provider Network Access & Availability standards

As a MedStar Family Choice DC participating provider, your office is expected to meet the following appointment guidelines:

- Waiting time in the office may not exceed 45 minutes.
- Initial appointments for new enrollees age 21 and older must be within 45 days of their enrollment date or within 30 days of the request, whichever is sooner.
- Initial appointments for new enrollees under the age of 21 must be within 60 days of enrollment or earlier if needed to comply with the EPSDT periodicity schedule.
- Initial assessment of pregnant or postpartum women and those requesting family planning services must be within 10 days of the request.
- Routine primary or specialty care (including EPSDT appointments that are due, IDEA services and physical exams) must be within 30 days of the request.
- Urgent care appointments must be within 24 hours of the request.
- Primary care providers must maintain twenty-four (24) hours per day, seven (7) days per week access for enrollees. During after-hours, this can be accomplished via an answering machine or answering service. Both methods must provide the enrollee with instructions on how to access their PCP or an on-call PCP. In the case of an emergency, the enrollee is to be instructed to call 911 or go to the nearest emergency room.

- Behavioral Health (BH) Providers Appointment Standards:
  - BH Provider must provide care for a non-life-threatening emergency within 6 hours.
  - The BH Provider office must direct enrollees with non-life-threatening emergencies to the ED or behavioral health crisis units.
  - The BH Provider must provide Urgent care within 48 hours.
  - The BH Provider must be able to schedule Initial visit for routine care within 10 business days.
  - The BH Provider must provide Follow-up routine care within 30 days of an appointment.

MedStar Family Choice DC conducts secret shopper surveys monthly to ensure that providers are compliant with the above requirements. If your office is found non-compliant with any of the above requirements, your provider relations associate will contact you with the specific details. Your office will then be re-surveyed within the next 60 days. If the office remains non-compliant; you will be asked to submit a thirty (30) day corrective action plan to resolve the deficiency. During the 30 days of the corrective action plan, the Provider office will not be allowed to see MedStar Family Choice DC enrollees.

Utilization Management Prior Authorization review process

To ensure Enrollees receive proper health care, we follow a basic prior authorization process. To request prior authorization, all appropriate Prior Authorization Request forms, ICD-10/CPT/HCPCS and supporting clinical information must be included with the Provider's request.

- For Non-Pharmacy requests, use the Non-Pharmacy & DME Prior Authorization Request Form or Uniform Consultation Referral Form located on the **MedStarFamilyChoiceDC.com/Providers/Utilization-Management** webpage and fax it to us at **202-243-6307.**
- For Pharmacy requests, use the appropriate Pharmacy Prior Authorization Request Form located on the **MedstarFamilyChoiceDC.com/Providers/Pharmacy** webpage and fax it to us at **202-243-6258.** The Pharmacy forms are as follows:
  - Opioid Prior Authorization Form
  - Pharmacy Prior Authorization/Non-Formulary Request Form

Our clinical staff reviews all requests, and prior-authorization decisions are based on medical necessity using nationally-recognized criteria, such as Inter-Qual, ASAM, and Medicare guidelines.

Additional authorization information can be found on the above listed Utilization Management and Pharmacy web pages or on our Medical Policies and Procedures page at **MedStarFamilyChoiceDC.com/Providers/Medical-Policies-and-Procedures.** Enrollees' needs that fall outside of standard

criteria are reviewed by our medical directors for plan coverage and medical necessity. We do not reward practitioners or other individuals for issuing denials of coverage of care.

Utilization Management decision-making is based only on the appropriateness of care and services and the existence of coverage. In addition, there are no financial incentives for Utilization Management decision-makers that would encourage decisions that result in underutilization. Providers will receive written communication detailing the rationale for adverse determination. Information on how to file an Appeal is also detailed in the denial letter. Providers may request a written copy of the criteria used in the decision-making process by contacting us at **855-798-4244** (select option 2 for Provider and then option 1 for Authorizations), Monday through Friday, from 8 a.m. to 5:30 p.m.

We highly encourage that authorization requests are made no less than seven business days in advance of the service. Please allow up to 5 business days for us to process a complete routine/ standard authorization request.

Requests are considered complete when all necessary clinical information received from the Provider has been reviewed thoroughly. The final decision is made within 5 business days from the initial authorization request, whether or not all clinical information has been received. For Enrollees with urgent authorization needs, a final decision is made as expeditiously as the Enrollee's health condition requires and within 24 hours of the request.

For Pharmacy requests, MedStar Family Choice DC must decide within 24 hours of the receipt of the request. Please ensure that all pertinent clinical information is provided with the request to prevent any denial of service for lack of clinical information. If we deny the prior authorization request, the Provider and Enrollee will receive a written copy of the denial and its rationale. Information on how to request an Appeal is also included in the denial letter.

Pharmacy – Formulary Updates

CHANGES BELOW BECAME EFFECTIVE ON OR AROUND JANUARY 1, 2026

Additions:

- **Unifine** Pen needles by Owen Mumford

Additions with Prior Authorization Requirement:

- None

Removals:

- **Ajovy**
- **Trulicity**
- **Orenitram**

Removal of Prior Authorization Requirement:

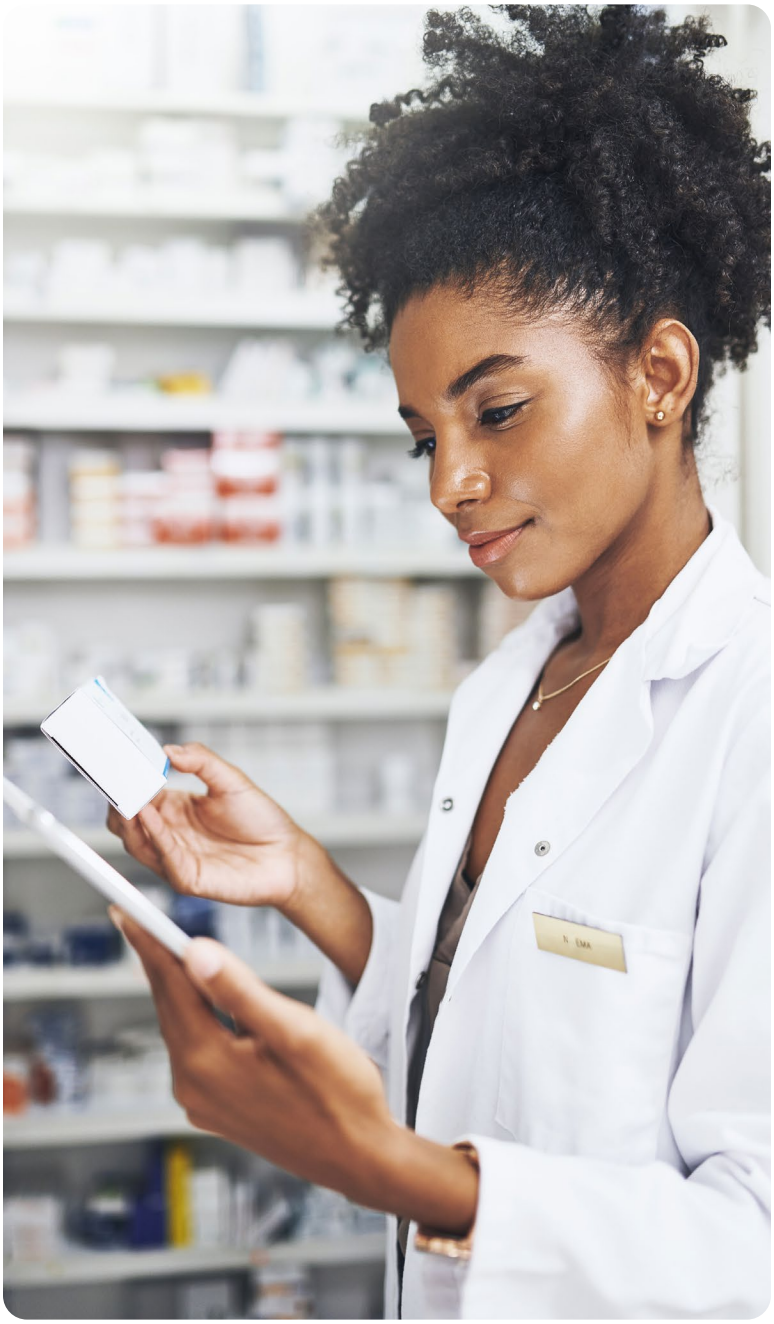
- None

Managed Drug Limitations & Step Therapy:

- Add a step therapy to Continuous Glucose Monitor products

The full formulary and list of formulary updates are available on the MedStar Family Choice DC Provider Website **MedStarFamilyChoiceDC.com/Providers/Pharmacy.**

The MedStar Family Choice DC P&T Committee welcomes your feedback. Providers can email feedback or requests for formulary additions or changes to: ≠**mfc-formularyfeedback@medstar.net**



Compliance Corner

The OIG Seven Elements of an Effective Compliance Program

The OIG's seven elements of an effective compliance program are essential for small practitioners' offices to ensure compliance with federal health care regulations.

Establishing and following a model compliance program will help physicians avoid fraudulent activities and ensure that they are submitting true and accurate claims. The following seven components provide a solid basis upon which a physician practice can create a voluntary compliance program:

These elements include:

Written Policies and Procedures: These should encompass the implementation and operation of the compliance program and processes to reduce risks caused by noncompliance with Federal and State laws.

Code of Conduct: A code of conduct and compliance policies are critical elements of any compliance program.

Leadership and Oversight: Leadership should commit to implementing all seven elements to achieve a successful compliance program.

Training: All employees must receive compliance training to protect both employees and patients.

Communication: Effective communication of compliance obligations to staff members is essential.

Auditing and Monitoring: Establish ongoing evaluation processes involving thorough monitoring and regular reporting.

Prompt Response and Corrective Action: Compliance audits by either internal or external auditors are recommended.

For more information on compliance programs for physicians, see the OIG's Compliance Program Guidance for Individual and Small Group Physician Practices.

These elements are designed to help small practitioners' offices create effective health care compliance programs that are integrated into their management practices. With the passage of the Patient Protection and Affordable Care Act of 2010, physicians who treat Medicare and Medicaid beneficiaries are encouraged to establish a compliance program.

Quality Improvement Corner – Why the CAHPS Survey Matters to Physicians

The healthcare landscape continues to shift toward value-based care, where patient experience is not just a "soft" metric — it has become a core component of quality measurement, reimbursement, and provider and health plan reputation. The NCQA CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey is conducted yearly from March through May and plays a central role, directly reflecting how patients perceive their care and their interactions with you as a physician.

Why CAHPS Matters to You

- Direct Impact on Reimbursement, Contracts, Quality Ratings, and Accreditation - CAHPS scores are embedded in many value-based payment models. Strong performance can enhance financial incentives, while poor scores may reduce them.
- Public Reporting and Reputation - Patient experience scores are increasingly transparent. Health plans and provider groups use CAHPS data in public reporting, affecting patient choice, referral patterns, and your professional reputation.
- Patient Retention and Loyalty - Patients who report positive experiences are more likely to adhere to treatment plans, maintain continuity of care, and recommend your practice.

Key CAHPS Domains and Questions That Reflect Physician Performance

While CAHPS includes multiple domains, several are directly influenced by physician behavior:

- Provider Communication
  - Were things explained to you in a way you could understand?
- How often did your personal doctor spend enough time with you?
- Getting Needed Care
  - How often was it easy to get the care, tests or treatment you needed?
  - How often did you get an appointment to see a specialist as soon as you needed?
- Care Coordination
  - For scheduled appointments, how often did your doctor have your medical records or other information about your care?
  - When your doctor ordered a blood test, X ray, or other test for you, how often did:
    - Someone from the doctor's office follow up to give you those results?
    - You get results from providers as soon as you needed them?

  - How often did your doctor seem informed and up to date about the care you got from specialists?
  - How often did you and your doctor talk about the prescription medicines you were taking?
  - How often did you get the help that you needed from your doctor's office to manage your care among different providers and services?
- Overall Rating of Healthcare Provider
  - Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

Focusing on the following areas can yield meaningful improvements for your practice and the plan:

Practical Strategies to Improve CAHPS Scores

Elevate Communication Quality

Patients consistently rate communication as one of the most important aspects of care.

- Use plain language and avoid medical jargon
- Pause frequently to ask, "What questions do you have?"
- Apply the "teach-back" method to confirm understanding
- Maintain eye contact and minimize screen time during visits

High-impact habit: Sit down during patient encounters, this simple action significantly improves perceived time spent and attentiveness.

Improve Access and Timeliness

Delays and barriers to care strongly influence CAHPS responses.

- Optimize scheduling templates to reduce wait times
- Offer same-day or next-day appointments when possible
- Leverage telehealth for appropriate visit types
- Ensure timely response to patient messages (ideally within 24 hours)

High-impact habit: Reserve a small number of daily slots for urgent visits.

Strengthen Care Coordination

Patients often feel the burden of navigating fragmented care.

- Clearly explain next steps, referrals, and follow-ups
- Ensure test results are communicated promptly even when normal
- Coordinate with specialists and close the loop on referrals
- Use care teams effectively (nurses, MAs, care coordinators)

High-impact habit: End every visit with a clear, concise summary of the care plan.

Enhance Office Workflow and Team Experience

CAHPS scores reflect the entire care experience not just the physician.

- Train staff on courtesy, empathy, and responsiveness
- Streamline check-in and check-out processes
- Keep patients informed about delays
- Foster a culture of patient-centered care across the team

High-impact habit: Conduct brief daily huddles to align staff on patient needs and workflow.

Build Trust Through Empathy

Patients who feel heard and respected consistently rate their care experience higher.

- Acknowledge patient concerns without interruption
- Validate emotions ("I can see why that's frustrating")
- Personalize interactions by referencing prior visits or history

High-impact habit: Spend the first minute of each visit listening without interrupting.

Turning Insight into Action

Improving CAHPS scores is not about scripting interactions or adding administrative burden—it is about refining how care is delivered in ways that matter most to patients. Small, consistent changes in communication, access, and coordination can lead to measurable improvements in both patient experience and clinical outcomes.

As healthcare continues to prioritize value, CAHPS performance will remain a key differentiator. Physicians who proactively engage with these metrics position themselves and their organizations for stronger patient relationships, better outcomes, and long-term success.

Please reach out to **quality.improvement@medstar.net** with any questions or desire for further educational materials.

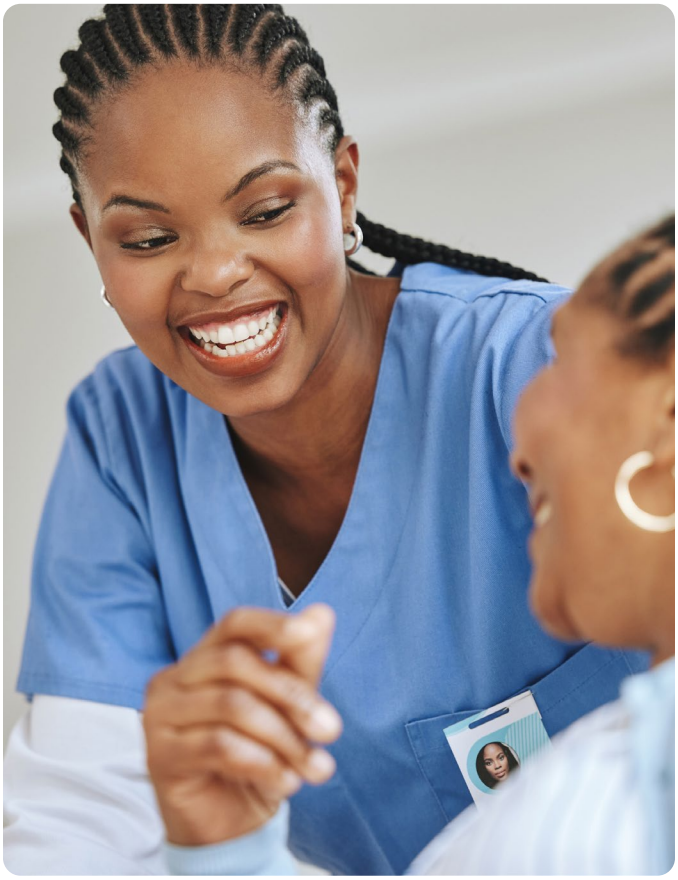
Know the rights and responsibilities of our enrollees

Enrollees have a right to:

- Know that when they talk with their doctors and other providers, it's private.
- Have an illness or treatment explained to them in a language they can understand.
- Participate in decisions about their care, including the right to refuse treatment.
- Receive a full, clear, and understandable explanation of treatment options and the risks of each option so they can make an informed decision.
- Refuse treatment or care.
- Be free from any form of restraints or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Can see and receive a copy of their medical records and request an amendment or change, if incorrect.
- Receive access to healthcare services that are available and accessible to them in a timely manner.
- Choose an eligible PCP/PDP from within MedStar Family Choice DC's network and to change their PCP/PDP.
- Make a Grievance about the care or services provided to them and receive an answer.
- Request an Appeal or a Fair Hearing if they believe MedStar Family Choice DC was wrong in denying, reducing, or stopping a service or item.
- Receive Family Planning Services and supplies from the provider of their choice.
- Obtain medical care without unnecessary delay.
- Receive a second opinion from a qualified healthcare professional within the network or, if necessary, to obtain one outside the network at no cost to them.
- Receive information on Advance Directives and choose not to have or continue any life-sustaining treatment.
- Receive a copy of MedStar Family Choice DC's Enrollee Handbook and/or Provider Directory.
- Continue the treatment they are currently receiving until they have a new treatment plan.
- Receive interpretation and translation services free of charge.
- Refuse oral interpretation services.
- Receive transportation services free of charge.
- Get an explanation of prior authorization procedures.
- Receive information about MedStar Family Choice DC's financial condition and any special ways we pay our doctors.
- Obtain summaries of customer satisfaction surveys.

- Receive MedStar Family Choice DC's "Dispense as Written" policy for prescription drugs.
- Receive a list of all covered drugs.
- Be treated with respect and due consideration for their dignity and right to privacy.

Enrollees are responsible for:



- Treating those providing their care with respect and dignity.
- Following the rules of the DC Medicaid Managed Care Program and MedStar Family Choice DC.
- Following instructions they receive from their doctors and other providers.
- Going to scheduled appointments.
- Telling their doctor at least 24 hours before the appointment if they must cancel.
- Asking for more explanation if they do not understand their doctor's instructions.
- Going to the Emergency Room only if they have a medical emergency.
- Telling their PCP/PDP about medical and personal problems that may affect their health.
- Reporting to Economic Security Administration (ESA) and MedStar Family Choice DC if they or a family Enrollee have other health insurance or if they have a change in their address or phone number.
- Reporting to Economic Security Administration (ESA) and MedStar Family Choice DC if there is a change in their family (i.e. deaths, births, etc.)
- Trying to understand their health problems and participate in developing treatment goals.
- Helping their doctor in getting medical records from providers who have treated them in the past.
- Telling MedStar Family Choice DC if they were injured as the result of an accident or at work.

If you have questions regarding information in this newsletter, please call us, Monday through Friday, 8 a.m. to 5:30 p.m., at 800-261-3371 (select option 1 or remain on the line).

You can also email us at **mfcdc-providerrelations@medstar.net.**

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