MedStar Family Choice

DISTRICT OF COLUMBIA

Provider Newsletter

Spring 2021

Welcome to MedStar Family Choice-DC.

Welcome to our network!

Prescription Drug Monitoring Program (PDMP) query required in DC.

Prescription Drug Monitoring Program Query and Omnibus Health Amendments Act of 2020 became effective on March 16, 2021. The Act requires prescribers and dispensers to query the PDMP:

- Prior to prescribing or dispensing an opioid or Benzodiazepine for more than seven consecutive days, and
- Every ninety days thereafter while the course of treatment or therapy continues, or
- Prior to dispensing another refill after ninety days.

Transportation now provided to DC Healthcare Alliance enrollees.

We now provide transportation services, through Access2Care, for both DC Healthy Families and DC Healthcare Alliance. If you have an enrollee who needs transportation for a medical appointment, including COVID-19 vaccinations, please remind them that transportation can be scheduled 24/7 by calling **866-201-9974**. Transportation must be scheduled at least three business days in advance for a regular appointment and one day in advance for EPSDT or urgent visits.

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Know our access and availability standards.

Providers must offer hours of operation to enrollees consistent with the items below and the provider's specialty. Department of Health Care Finance (DHCF) regulations require providers to adhere to the following guidelines for appointment scheduling:

Office hours for enrollees must be equivalent to those offered to commercial, Medicare, or Medicaid fee-for-service beneficiaries.

Patient wait time may not exceed 30 minutes after the scheduled appointment time to be seen for regular office visits (this does not apply to patients who are added to the schedule last minute and advised that they will be seen at the first available time).

Throughout the year Provider Relations will monitor our provider network for adherence to these requirements. In addition, DHCF also regularly conducts secret shopper activities to determine adherence. In the event your office is identified as not meeting requirements, you will be contacted by Provider Relations.

Follow corrected and voided claim requirements for prompt payment.

Did you know that submitting claims incorrectly could delay or even result in denial of payments? Please make sure to follow the corrected and voided claim requirements to avoid any delays or denials of claim payments.

837P (Professional) Electronic Claims

When submitting a corrected or voided claim, MedStar Family Choice-DC (MFC-DC) prefers to receive a corrected or voided claim electronically. Follow the Loop and CML segment as instructed below when submitting a corrected or voided claim. In Loop 2300 (Claim Information), the CLM segment must have one of these qualifier codes:

- CLM05-3 – include the number "7" (Replacement); the corrected claim will process as a replacement claim and reverse the original claim on file.
- CLM05-3 – include the number "8" (Void); the original claim on file will be voided and any previous payments will be recouped.

The REF*F8 segment must include the original claim number, exactly as it appeared in the original claim being corrected—no additional characters.

CMS 1500 Professional Paper Claims

When submitting a corrected or voided claim by paper using the CMS 1500 form, follow the below instructions.

In Field Locator 22 include the number "7" as the Resubmission Code to indicate the claim is a replacement claim or the number "8" to indicate the claim is a voided claim. Include the original claim number in Field Locator 22 labeled "Original Ref No".

837I (Institutional) Electronic Claims

When submitting a corrected or voided claim, MFC-DC prefers to receive a corrected or voided claim electronically. Follow the Loop and CML segment as instructed below when submitting a corrected or voided claim. In Loop 2300 (Claim Information), the CLM segment must have one of these qualifier codes:

- CLM05-3 – include the number "7" (Replacement); the corrected claim will process as a replacement claim and reverse the original claim on file.
- CLM05-3 – include the number "8" (Void); the original claim on file will be voided and any previous payments will be recouped.

The REF*F8 segment must include the original claim number, exactly as it appeared in the original claim being corrected—no additional characters.

UB-04 Institutional Paper Claims

When submitting a corrected or voided claim by paper using the UB-04 form, follow the below instructions.

In Field Locator 4 update the Bill Type using the number "7" as the third digit (XX7) to indicate the claim is a replacement claim or the number "8" as the third digit (XX8) to indicate the claim is a voided claim. Include the original claim number in Field Locator 64.

If the above required information is missing from the corrected or voided claim, MFC-DC will deny the corrected or voided claim and request the claim be resubmitted with all the necessary information to adjudicate the claim.

All corrected and voided claims must be received within 365 days from the date of service or 90 days from the date of the original claim denial.

Avoid timely filing denials.

In order for payment to be issued a clean claim must be resubmitted within 365 days from the date of service. After 365 days, any claim submitted will be denied as untimely and the claim will not be paid. If the claim is first submitted to another insurance carrier (commercial, Medicaid fee-for-service, etc.), it must be submitted to MedStar Family Choice-DC (MFC-DC) within 180 days from the date of the Explanation of Benefits (EOB) of the primary carrier. Providers are required to submit the EOB to MFC-DC with the claim following receipt.

We do not accept billing system printouts as proof a claim was filed in a timely manner. Providers should make every effort to submit their claims as soon as possible. This allows providers additional time to submit corrected new claims within the 365-day timeframe.

Children's dental health part of EPSDT.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, also known as HealthCheck in DC, is a mandatory Medicaid benefit for District of Columbia children that includes preventive and specialty care, including dental services. Preventive care rendered by primary care providers during a well-child visit includes oral health assessments for all ages and fluoride varnish application for children under the age of 3. Comprehensive oral exams, dental sealants, and dental cleanings are also covered, as well as any needed diagnostic or treatment services identified by dental providers.

Recently, local and national data have shown a decline in services used by children covered by Medicaid, indicating that children and families have likely been delaying necessary medical and dental health care during the COVID-19 pandemic. These delays in care can result in missed opportunities to manage chronic conditions or diagnose and treat other health issues. In this challenging time, it remains critical for pediatric Medicaid beneficiaries to receive all necessary services included in the EPSDT benefit, including well-child visits (through telemedicine and in-person appointments) and preventive dental screenings.

New federal rules require Medicaid MCO providers to register and become credentialed with Medicaid fee-for-service.

Medicaid Managed Care Organization (MCO) providers are required to register and become credentialed with Medicaid fee-for-service (42 CFR Part 438, Subpart H). Providers should register with the new **DC Provider Data Management System** (DCPDMS). We will not accept any new provider credentialing applications without a DC Medicaid provider number. DCPDMS is now the one-stop source for access to provider registration and demographic changes.

If your organization is a group practice, please register your group practice first. As part of your group registration, you will be able to add rendering providers within DCPDMS. After you initiate a rendering provider affiliation, the rendering provider must access DCPDMS under his or her separate user profile to accept your affiliation, complete the registration, and sign using his or her eSignature. If you are a solo practitioner, you will select "solo practitioner" when prompted in DCPDMS and disregard the above paragraph regarding the addition of rendering providers.

Providers not located in the District of Columbia should complete the same process on the DCPDMS website. If you have registration questions, please call us at **855-798-4244** (select option 2 for Provider and then option 2 for Provider Relations).

REMINDER: All claims submitted from participating providers that do not have an active/valid DC Medicaid provider number on file with DHCF and DCPDMS with a date of service on or after January 1, 2020 will not be reimbursed.

Ensure EPSDT quality of care.

The District of Columbia Department of Health Care Finance (DHCF) annually evaluates the quality of care provided to Managed Care Organization (MCO) enrollees that meet criteria for HealthCheck, the District's EPSDT program. DHCF contracts with Qlarant to serve as External Quality Review Organization (EQRO). On October 1, 2020, Qlarant began performing an annual medical record review of completed preventive services in accordance with the **District's HealthCheck Periodicity Schedule** for children up to the age of 20.

MCOs are assessed using five components including: Health and Developmental History; Comprehensive Physical Examination; Laboratory Tests/At-Risk Screenings; Immunizations; and Health Education/Anticipatory Guidance. A minimum performance score of 80% is required for each component.

Additionally, EPSDT certified providers are required to follow guidance from the District of Columbia Department of Health Immunization Schedule as well as age-specific EPSDT developmental forms and preventive screen questionnaires. EPSDT certified providers are strongly encouraged to use the **District of Columbia Immunization Information System** (DOCIIS) website for tracking and updating immunizations and to follow up with lab results and referrals. We recommend providers include complete medical record documentation in order to support rendered EPSDT services.

DHCF makes helpful forms available for use by providers on their website at **DCHealthCheck.net/trainings/documentation/epsdt/index.html**. If you are unable to print a copy of any of the EPSDT forms, call us at **855-798-4244** (select option 2 for Provider and then option 2 for Provider Relations), and a copy will be provided to you.

HEDIS® compliance audits are required.

Completing the National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™ is required of Managed Care Organizations (MCOs) operating in the District of Columbia. Under the regulations, MCOs report designated subsets of the Medicaid HEDIS® measures. We are collecting baseline data throughout 2021 and will benchmark our performance against other DC Medicaid MCOs and the NCQA Means and Percentiles Report.

The Department of Health Care Finance (DHCF) and NCQA require MCOs to submit all measures required for maintenance of NCQA accreditation and other measures at the DHCF's discretion. Thank you in advance for your cooperation and assistance in getting our enrollees into care. As we continue to improve and strive for high scores, your dedication to quality health care is very much appreciated.

NCQA HEDIS Compliance Audit™ and HEDIS® are trademarks of the NCQA. NCQA accredits and certifies a wide range of healthcare organizations and manages the evolution of HEDIS®.

Gynecological services available without referral.

Enrollees may schedule annual and/or routine gynecological care, including Pap smears and examinations with either an in-network primary care physician or an in-network gynecologist, without a referral. Referrals and prior authorization are required for all out-of-network providers. If an enrollee inquires about a gynecologist please direct the enrollee to our Find-a-Provider directory at **MedStarFamilyChoiceDC.com**,or contact us at **855-798-4244** (select option 2 for Provider and then option 2 for Provider Relations), to request a listing of participating gynecologists.

Ensure patient privacy and security during (and after) the COVID-19 national emergency.

The HIPAA Privacy and Security Rules regulate what can and cannot be done with certain types of health information. In addition to HIPAA, providers must comply with other applicable federal, state, and local laws which govern privacy requirements. The HIPAA Privacy Rule covers protected health information (PHI) in any medium.

The HIPAA Security Rule covers electronic protected health information (ePHI). A few simple steps can help protect patient privacy daily. These tips include:

- Do not leave PHI in areas where it can be viewed or accessed by unauthorized personnel.
- Sign-in sheets should not state the reason for the patient's medical appointment.
- Face sheets should be turned toward the wall if patient charts are outside of an examination room.
- Keep confidential conversations at a low level.
- Leave minimum necessary information regarding appointments on patients' voicemails.
- Computers/workstations should be in an area that minimizes accidental/non-authorized viewing of patient information.
- Assign strong passwords to computer systems.
- Do not share user IDs or passwords.
- Do not post passwords in or around workstations where they can be viewed easily by others.
- Always log off of computers/workstations when leaving work for a long period of time or lock computers when away from the workstation.
- Add password-protected screensavers to personal workstations.
- Protect electronically transmitted PHI through encryption and password protect electronic patient information.
- Save PHI data to the appropriate locations and in the appropriate manner so the data is backed up regularly.
- Properly dispose of any documents or papers containing PHI in shredders or special destruction boxes.

Visit the U.S. Department of Health and Human Services website at **HHS.gov** and **HealthHit.gov** for more information regarding HIPAA rules.

Case Management Services and other available benefits.

Case Management Services are provided by highly-qualified registered nurses, social workers, and coordinators. These professionals assist enrollees in the management of their complex bio-psycho-social needs. This is done telephonically by educating the enrollee on disease self-management, facilitating access to health care, and connecting the enrollee to needed resources within the community. Case managers work closely with providers to ensure that their enrollees receive appropriate and timely health care. The Case Management staff will work closely with providers to obtain clinical information and to ensure that needed services are completed.

Types of Case Management Services

Complex Case Management (CCM)

We provide Complex Case Management Services to our most complex and highest risk enrollees that including, but not limited to those experiencing a critical event or diagnosis that requires care coordination and/or extensive use of resources. A critical event or diagnosis includes, but is not limited to the following:

- Amyotrophic Lateral Sclerosis (ALS)
- Hemophilia or Coagulation Disorders
- Guillain-Barre Syndrome
- Liver Failure
- Cystic Fibrosis
- Respiratory Failure
- Ventilator Dependency
- Burns > 20% of total body surface area or 2nd/3rd Degree
- Spinal Cord Injuries
- Paraplegia with Complications
- Severe Cognitive Functional Impairment
- Sickle Cell Disease
- Malignant Neoplasms (a very expansive list of tumors)
- Cerebrovascular Accident (Stroke)
- Cerebrovascular Hemorrhage
- Osteomyelitis
- Sepsis
- Transplants
- Hemiplegia
- Acute trauma with complex care coordination needs
- Gaucher's Disease
- Lymphatic and Hematopoietic (blood) system disorders

Enrollees identified by the District of Columbia Health Care Finance (DHCF) as 'Special Needs Population' include:

- Adults and children with special healthcare needs.
- Individuals with a physical disability.
- Individuals with a developmental disability.
- Pregnant and postpartum women.

Comprehensive Case Management Services

Comprehensive Case Management Services are available to MedStar Family Choice-DC MFC-DC adult and pediatric enrollees with certain medical conditions. Inclusion criteria for adult enrollees include but is not limited to:

- High Risk Pregnancy
- Diabetes
- Asthma
- COPD
- Hypertension
- Cardiovascular Disease
- HIV
- Substance Use Disorder
- Social Issues/Mental Health

Inclusion criteria for pediatric enrollees include but is not limited to:

- Diabetes
- Asthma
- Obesity
- Epilepsy
- Chronic Lung Disease
- Cardiovascular Disease (CAD)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Depression
- Anxiety
- Substance Use Disorder
- Other Mood Disorder

Transition Care Case Management Services

Transition Care Case Management is a service provided by MFC-DC to assist your patient, identified as high risk for readmission when transitioning from the hospital to home. This service is provided by registered nurse case managers who work closely with your patient to assist with adherence to the discharge plan ordered by the hospital care team, locating providers, scheduling follow-up appointments, and assisting with transportation if needed. This service is offered for 30 days, and if after that time your patient requires further assistance, they will be referred to one of our other case management services.

Continued on next page

Enrollment

Enrollee participation in Complex Case Management, Comprehensive Case Management, or Transition Care Services is voluntary and enrollees can start, stop, or decline participation at any time. However, they are automatically included in the programs once identified by us as meeting qualifying criteria. Adults with special healthcare needs as defined by DHCF are mandated to be in some level of perpetual Case Management.

To refer your enrollee to any of the above services, please fax your referral to **202-243-6253**, send a secured email to **DCMFCCaseMgmt@medstar.net**, or call us at **855-798-4244** (select option 2 for Provider and then option 1 for Care Manager). We are available Monday through Friday from 8 a.m. to 5:30 p.m. Any faxes or voice messages received after hours will be handled the next business day.

Additional enrollee benefits

Resource Connection

A case manager can connect your patients with resources in their community to assist them with mental and/or substance use needs, utility turn-offs, food assistance, and emergency shelters. Printed educational materials with information on chronic conditions are available for enrollees. The information is written in easy to understand language. A case manager is available to answer your patient's questions and concerns, and to advise on wellness incentives that may be available to them.

Coordinate Care

A case manager can assist your patient with locating a specialist in their area, as well as scheduling appointments and coordinating transportation based on your patient's needs. For more information, call **855-798-4244** (select option 2 for Provider and then option 1 for Care Manager).

Report fraud, waste, and abuse.

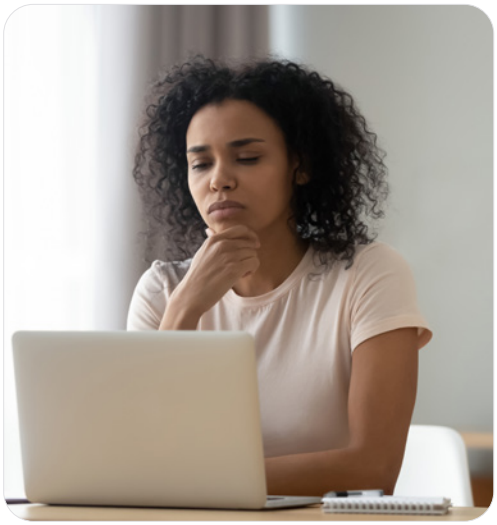
MedStar Family Choice-DC (MFC-DC) has a compliance program in place to monitor and detect noncompliance with Medicaid requirements and guidelines. Fraud, waste, and abuse is a form of noncompliance which can be committed by a provider, enrollee, or employee associated with the managed care organization's transactions. As a contracted provider, it is your responsibility to report suspected or confirmed incidents of fraud, waste, or abuse.

Providers identifying fraud, waste, and abuse activity must report it immediately by contacting us. There are numerous ways in which providers can report compliance issues. If you know of a situation that may be confirmed or you suspect to be fraud, waste, and abuse, report it immediately. Your report will remain confidential and anonymous as possible by calling or contacting one of the following resources.

- MedStar Health Integrity Hotline: **877-811-3411**
- Enrollee Services: **888-404-3549**
- Website for compliance reporting: **Compliance-Helpline.com/MedStar.jsp**
- MedStar Health Office of Corporate Business Integrity (OCBI): **compliance@medstar.net** or **410-772-6606**
- Department of Health Care Finance Fraud Hotline: **877-632-2873**

A strict non-retaliation policy is in place for reporting known or suspected fraud, waste, and abuse. Some common examples of fraud, waste, and abuse are:

- Billing for a service that was never performed.
- Unbundling of procedures.
- Up-coding.
- Performing unnecessary procedures.
- Altering or forging a prescription.
- Allowing others to use an enrollee's ID card for health care.
- Inappropriate use of Medicaid resources.



Many billing errors are oversights and are not indicators of fraudulent activity. However, fraud, waste, and abuse can be identified through various investigative techniques and methods. MFC-DC implements actions to monitor, identify, and deter these types of activities. We regularly monitor and audit claim submissions and encounter data. In addition, we perform routine and random chart audits as a part of the compliance program.

Providers are required to comply with compliance audits. If overpayments related to fraudulent or abusive billing have been identified, we may retract those payments which we may be required to notify the Department of Health Care Finance which may perform its own investigation. Penalties such as fines, loss of licensure, or imprisonment can occur for providers found guilty of knowingly participating in fraudulent activity.

If an investigative audit identifies a potential of fraud, waste, and abuse event, providers will be notified in writing, are afforded appeal rights and have 90 days from receipt of notification to file a written appeal. Appeals and refund checks should be sent to:

MedStar Family Choice-DC
Attention: Director of Medicaid Contract Oversight
3007 Tilden Street, NW
POD 3N
Washington, DC 20008

Please note: When in the course of regular business, as part of an internal compliance program, or as a result of a self-audit, a provider determines that payments received were in excess of the amount due, the provider is obligated to report and return the improper amounts within 60 days of receipt.

How utilization management authorization review works.

To ensure enrollees receive proper health care, we follow a basic prior-authorization process. To request prior-authorization, all appropriate ICD-10/CPT/HCPCS and supporting clinical information must be included with the provider's request. Requests for referrals or authorization can be included on our Uniform Consultation Referral Form or the applicable Prior Authorization (Pharmacy, Non-Pharmacy, Pain Management, DME & PCA) Request Form respectively. Clinical information must be submitted with the request. Our experienced clinical staff reviews all requests, and prior-authorization decisions are based on nationally-recognized criteria, such as Inter-Qual and Medicare guidelines. Additional authorization criteria can be found at **MedStarFamilyChoiceDC.com** in our utilization management (UM) criteria policy.

Enrollee's needs that fall outside of standard criteria are reviewed by our medical directors for plan coverage and medical necessity. We do not specifically reward practitioners or other individuals for issuing denials of coverage of care. UM decision making is based only on appropriateness of care and services and existence of coverage. In addition, there are no financial incentives for UM decision makers that would encourage decisions that result in underutilization. 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. Authorization requests should be made no less than five to seven business days in advance of the service.

Please allow up to 14 days for us to process a complete authorization request. Requests are considered complete when all necessary clinical information has been received from the provider. The final decision is made within 14 calendar days from the initial request for authorization, whether or not all clinical information has been received. For enrollees with urgent authorization needs, providers and/or staff should contact us at **855-798-4244** (select option 2 for Provider and then option 1 for Authorizations/Care Manager). If we deny the prior authorization request, the provider and enrollee will receive a written copy of the denial and its rationale. In addition, the denial letter will indicate that the treating provider may contact the medical director who made the decision to discuss the case by calling **855-798-4244** (select option 2 for Provider and then option 1 for Authorizations/Care Manager).

Interpreter services are available.

Cultural and linguistic differences can create barriers between providers and patients. These barriers may hinder healthcare professionals from understanding patient needs. Providers can positively enhance a patient-physician relationship by:

- Being focused on the patient during the visit.
- Asking clear and concise questions.
- Following up with additional questions to ensure the enrollee understands the provider's instructions.

For enrollees that are hearing impaired or not proficient in English, we will provide telephonic interpretation services and/or professional on-site interpreters. Please contact us at **855-798-4244** (select option 2 for Provider and then option 2 for Provider Relations), to schedule these services.

A direct link to the Cultural Diversity Training online is available on the **MedStar Family Choice Provider Resources webpage**.

Know the rights and responsibilities of our enrollees.

Enrollees have certain rights and responsibilities. These rights and responsibilities are reviewed annually and can be found in our Enrollee Handbook and Provider Manual; both can be found at **MedStarFamilyChoiceDC.com**. Please contact us at **855-798-4244** (select option 2 for Provider and then option 2 for Provider Relations), with questions and comments or to request a hard copy of all materials.

MedStar Family Choice-DC (MFC-DC) enrollees have the right to:

- Know that when they talk with their doctors and other providers it is 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 risks of each option so they can make informed decisions.
- Refuse treatment or care.
- Be free from any form of restraints or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- 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 our network and to change their PCP/PDP.
- Make a Grievance about the care provided to them and receive an answer.
- Request an Appeal or a Fair Hearing if they believe MFC-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 information on Advance Directives and choose not to have or continue any life-sustaining treatment.
- Receive a copy of our Enrollee Handbook and/or Provider Directory.
- Continue 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 our financial condition and any special ways we pay our doctors.
- Obtain summaries of customer satisfaction surveys.
- Receive our “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.
- Receive health care and services that are culturally competent and free from discrimination.
- Receive information, including information on treatment options and alternatives, regardless of cost or benefit coverage, in a manner the enrollee can understand.
- Exercise their rights, and that the exercise of those rights does not adversely affect the way we, our providers, or the Department of Health Care Finance treats them.
- File appeals, grievances and Fair hearings with the District of Columbia.

- Request that ongoing benefits be continued during an appeal or state fair hearing however, the enrollee may have to pay for the continued benefits if the decision is upheld in the appeal or hearing.
- Receive a second opinion from another doctor within MFC-DC, or by an out-of-network provider if the provider is not available within MFC-DC, if the enrollee does not agree with the doctor's opinion about the services that the enrollee needs.
- Receive other information about how MFC-DC is managed including the structure and operation, as well as physician incentive plans.
- Receive information about MFC-DC, its services, its practitioners and providers and enrollee rights and responsibilities.
- Make recommendations regarding the organization's enrollee rights and responsibilities policy.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

Enrollees have the responsibility to:

- Inform their provider and us if they have any other health insurance coverage.
- Treat DHCF staff, our staff, and health care providers and staff, with respect and dignity.
- Follow the rules of the DC Medicaid Managed Care Program and MFC-DC.
- Follow instructions received from their doctors and other providers.
- Be on time for appointments and notify providers as soon as possible if they need to cancel an appointment.
- Go to scheduled appointments.
- Tell their doctor at least 24 hours before the appointment if you must cancel.
- Ask for more explanation if they do not understand their doctor's instructions.
- Go to the Emergency Room only if they have a medical emergency.
- Tell their PCP/PDP about medical and personal problems that may affect their health.
- Report to Economic Security Administration (ESA) and us if they or a member of their family (who is an enrollee) has other health insurance or if they changed their address or phone number.
- Report to ESA and us if there is a change in their family (i.e. deaths, births, etc.).
- Try to understand their health problems and participate in developing treatment goals.
- Help their doctor in getting medical records from providers who have treated them in the past.
- Tell us if they were injured as the result of an accident or at work.
- Show their enrollee ID card when they check in for every appointment.
- Report lost or stolen enrollee ID cards to MFC-DC.
- Call us if they have a problem or a complaint.
- Work with their Primary Care Provider (PCP) to create and follow a plan of care that the enrollee and PCP agree on.
- Ask questions about their care and let their provider know if there is something they do not understand.
- Update the District of Columbia Government (ex: DHCF, ESA) if there has been a change in their eligibility status.
- Provide us and our providers with accurate health information in order to provide proper care.
- Tell their PCP as soon as possible after they receive emergency care.
- Inform their caregivers about any changes to their Advance Directive.
- Supplying information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

Formulary update.

Details of prior authorization criteria, including additional protocols, are available on our pharmacy website. For more information, please call us at **855-798-4244** (select option 2 for Provider and then option 2 for Provider Relations).

CHANGES BELOW EFFECTIVE APRIL 1, 2021

Additions:

- Uribel (Methenamine/Sodium Phosphate Monobasic/Phenyl Salicylate /Methylene Blue/ Hyoscyamine Sulfate) Cap 118 mg
- Udenyca (pegfilgrastim-cbqv) 6 mg/0.6 mL
- Adakveo (crizanlizumab-tmca) Inj 100/10ml
- Rybelsus (semaglutide)

Additions with Prior Authorization:

- Syprine (trientine hydrochloride) Cap 250mg
- Trikafta (elexacaftor, ivacaftor, and tezacaftor) Tab
- Orilissa (elagolix) Tab
- Cosela (trilaciclib)
- Lupkynis (voclosporin)
- Benlysta (belimumab)

Removals:

None

Removals of Prior Authorization:

None

Managed Drug Limitations & Step Therapy*:

None

* Details of the step therapy criteria are on our website in the Step Therapy Table.

Know our excluded medications.

We do not cover medications used for fertility, cosmetic reasons, or erectile dysfunction. Our formulary was intentionally lenient during open enrollment from October 1- December 31, 2020, in order to minimize therapeutic disruption for enrollees. However, beginning April 1, 2021 we will no longer pay for medications from these classes.

If you have questions, please call us, Monday through Friday, 8 a.m. to 5:30 p.m., at **855-798-4244** (select option 2 for Provider and then option 2 for Provider Relations). You can also email us at **mfcdc-providerrelations@medstar.net**.

Provide equal access to appointments.

Civil rights are personal rights guaranteed and protected by the U.S. Constitution and federal laws. President Biden recently signed an executive order preventing and combating discrimination on the basis of gender identity or sexual orientation.

Nondiscrimination laws and regulations prohibit discrimination and require covered entities like providers to provide individuals an equal opportunity to participate in a program activity regardless of race, color, national origin, age, disability, sex, or (under certain conditions) religion.

Providers must provide the same access standards for all patients, regardless of the payer source. An example of discrimination includes offering fewer appointment slots or reduced office hours to Medicaid managed care beneficiaries than to commercially-insured or Medicaid fee-for-service beneficiaries. Services may not be denied or performed in a different manner because of discrimination. Enrollees may not be subjected to segregation or separate treatment in violation of a law, regulation, or another requirement.

In accordance with Title VI of the Civil Rights Act, we provides translation services, utilize 7-1-1 for the hearing impaired, and perform site visits to confirm disability accessibility. Providers must ensure that patients with impairments, or who require accessibility assistance, are provided with services.

Providers can contact us for assistance and report equal access or discrimination concerns to us at **855-798-4244** (select option 2 for Provider and then option 2 for Provider Relations).

If you have questions regarding information in this newsletter, please call us, Monday through Friday, 8 a.m. to 5:30 p.m., at **855-798-4244** (select option 2 for Provider and then option 2 for Provider Relations). You can also email us at **mfcdc-providerrelations@medstar.net**.

This Provider Newsletter is a publication of MedStar Family Choice-DC. Submit new topics for subsequent publication consideration to **mfcdc-providerrelations@medstar.net**.

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MedStar Family Choice

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It's how we treat people.

MedStarFamilyChoiceDC.com

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DHCF Department of Health Care Finance

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MURIEL BOWSER, MAYOR

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